Patient Self Assessment:

Patient Name:_____ Date:_____

What brings you to Physical Therapy today? _____

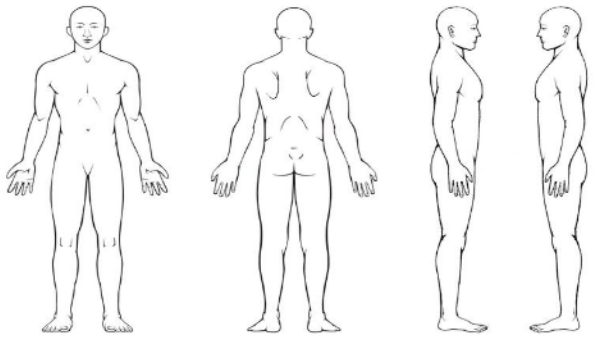
_____

Describe HOW and WHEN your symptoms started: Please Note date of Injury or Surgery:

_____

_____

Mark your Symptoms on the body chart:
By shading the area of pain.



Rate your CURRENT pain level:
0 1 2 3 4 5 6 7 8 9 10
No Pain Severe Pain

Rate your pain level in the LAST WEEK:
0 1 2 3 4 5 6 7 8 9 10
No Pain Severe Pain

What makes your symptoms/pain worse?_____

_____

What makes your symptoms/pain better? _____

_____

Does the pain wake you at night? ☐ Yes ☐ No How Often? _____

Has this problem affected your daily life or routine? Please explain: _____

_____

Have you undergone any special tests or imaging for this condition? ☐ Yes ☐ No

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If YES, Do you know the results? Where were the imaging done? _____

Have you experienced these symptoms or anything similar to this in the past? ☐ Yes ☐ No
Please Explain: _____

Have you had Physical Therapy for this problem in the past? ☐ Yes ☐ No
When? _____ Where? _____ Outcome? _____

Please Check all that Apply:

☐ Alzheimer's ☐ Cardiovascular Disease ☐ Stroke ☐ Current Infection ☐ Diabetes Type_____
☐ Fibromyalgia ☐ Fracture ☐ High Blood Pressure ☐ History of Cancer ☐ Osteoarthritis
☐ Parkinsons ☐ Rheumatoid Arthritis ☐ Traumatic Brain Injury ☐ Back Pain ☐ Pacemaker
☐ Allergies to Heat or Ice ☐ Are you Pregnant? _____

Any other Illness/Injuries I should be aware of? _____

List past surgeries: _____

List Current Medication: _____

_____

Weight? _____ Height? _____ Occupation? _____

Activity Level: ☐ Yes ☐ No How Often? _____ Type? _____

Do you Smoke? ☐ Yes ☐ No How Often? _____ How many years? _____

Please List your Goals and Aspirations for Physical Therapy:

1) _____

2) _____

Thank You. We are looking forward to working with you!

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