ADVANCE Orthopedic and Sports Therapy, P.C.

Patient's Self Evaluation of Current Status

Name: _____ Sex _____ DOB_____ Date _____

Height _____ Weight _____ R-Handed _____ L-Handed _____Occupation:_____

Please indicate the body region you are seeking treatment: <u>Please Circle Below</u>

Neck Mid-Back Low-Back Shoulder Elbow Hand/wrist Hip Knee Ankle/foot Other

When did your symptoms start? Date: _____ Can you identify a cause? Yes_____ No_____
If yes please specify**:** _____
Have you ever had similar symptoms in the past? Yes_____ No_____ If yes, when? _____
_____

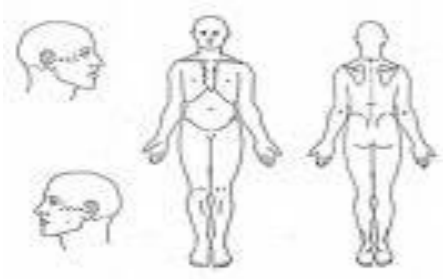
Have you recently had the following Tests? **<u>Please Circle</u>**

a. X-rays
b. CT Scan
c. MRI
d. Bone Scan
e. EMG
f. EKG
g. Stress Test
h. Other_____

Using the pain scale below please indicate your level of pain by CIRCLING the appropriate number:

0 1 2 3 4 5 6 7 8 9 10
Pain free Unconscious pain

Please use the diagram to indicate where your pain is.



How would you describe your pain (sharp, dull, ache, etc.?)
_____
Is the pain constant? Yes_____ No_____
Does the pain radiate/move anywhere? Yes_____ No_____
If so, where**?** _____
Do you have numbness, tingling, or weakness? Yes_____ No_____
If so, where? _____

Have you had any changes in bowel, bladder, or sexual function as a result or your symptoms? Yes_____ No_____
Describe: _____
What activities/positions make your pain worse? _____
What activities/positions make your pain better? _____
_____

Have you seen anyone else for this problem? **Please circle**

a. Physician
b. Physical Therapist
c. Chiropractor
d. Osteopath
e. Podiatrist
f. Dentist
g. Other (please list)
_____
_____

Are you currently taking any of the following **over the counter medications**?

- o Aspirin
- o Advil/Aleve/Ibuprofen
- o Decongestants
- o Laxative
- o Antihistamines
- o Supplements
- o Antacid
- o Tylenol
- o Vitamins
- o Other_____

Please list the prescribed medications you are taking here:

_____
_____
_____

Are you currently pregnant? Yes_____ No_____
Have you ever been pregnant? Yes_____ No _____
How many children do you have? _____ Are there any children in the home requiring you to lift or carry them for any reason? Yes_____ No_____ If yes, please explain:

_____
_____

Please check if you have ever been diagnosed as having any of the following conditions?

() cancer
() heart problems
() circulation problems
() high blood pressure
() emphysema/bronchitis
() arthritic condition
() rheumatoid arthritis
() depression
() tuberculosis
() kidney disease
() epilepsy
() bladder dysfunction
() stroke
() headaches
() numbness/tingling
() chemical dependency
() thyroid problems
() diabetes
() asthma
() multiple sclerosis
() hepatitis
() anemia
() bowel dysfunction
() allergies
() autoimmune deficiency
() vision problems
() marked weight gain or loss

RATING SCALE: For each activity listed below, please rate appropriately by numbers using the scale below:

1-Not at all painful 2-Somewhat painful 3-Moderately painful 4-Very painful 5-Extremely painful

ACTIVITY/SKILL	CAN DO	CAN NOT DO	PAIN LEVEL	FUNCTION BEFORE INJURY
Rolling over in bed				
Transfer to/from bath				
Bathing				
Dressing				
Grooming				
Going down stairs				
Going up stairs				
Transfer to/from car				
Driving				
Sitting				
Standing				
Walking				
Lifting				
Stooping/squatting				
Carrying				
Reaching for an object				
Using telephone				
Meal preparation				
Child care				
Household cleaning				
Other:				
Other:				
Other:				

Job Description: (physical tasks, amount of sitting, lifting, computer work, stair climbing etc.)

_____

_____

What do you hope to accomplish from your course of physical therapy treatment?

_____

_____

_____ _____

Patient's Signature Date

_____ _____

Evaluating Physical Therapist's Signature Date