Hands on HealthCare
Initial Evaluation Subjective Report

Today's Date__________________

Name ____

Family Physician____Phone_________________

Referring Physician____Phone_________________

Occupation___________________________________Currently working?______Hrs/wk__________

Email address____

THE FOLLOWING IS VERY IMPORTANT IN THE EVALUATION PROCESS. PLEASE FILL OUT QUESTIONS AS SPECIFICALLY AS POSSIBLE TO PROVIDE A CLEAR PICTURE OF YOUR PRESENT FUNCTIONAL ABILITIES AND SYMPTOMS.

1. History of Illness/Injury.

Is injury related to: Work_________Auto___________Home__________Other__________

Date of injury/Onset of symptoms_________________

Have you previously been treated for this problem?__________Did it help?____________

What treatments did you receive?____

Were x-rays taken?______________MRI ?________________________

2. What is your primary complaint that brings you to therapy? Please describe your symptoms as specifically as possible.

3. On the lines below, put a slash mark to indicate your functional ability as a % of normal.

On a good day 0%____100%

On a bad day 0%____100%

4. Put a slash mark on the line below to rate your **Intensity** of your symptoms:

No pain ____ Worst pain imaginable

Put a slash mark on the line below to rate the **Frequency** of your symptoms:

No pain____ Constant pain

5. What are **your** goals for Physical Therapy? For example, what activities do you want to perform longer or better? How long in hours or minutes do you want/need to perform each activity?

6. Do you have a history of;

	Yes	**No**		**Yes**	**No**
Circulatory problems	_____	_____	Blackouts	_____	_____
High blood pressure	_____	_____	Visual disturbances	_____	_____
Heart trouble	_____	_____	Weight changes(>15 lbs.)	_____	_____
Pacemaker	_____	_____	Headaches	_____	_____
Epilepsy	_____	_____	Ringing in ears	_____	_____
Diabetes	_____	_____	Bowel/Bladder Problems	_____	_____
Pregnancy	_____	_____	Malignancy	_____	_____
Stroke	_____	_____	Arthritis	_____	_____

7. Please list any allergies____

8. Medications currently taking____

9. Past Medical History: Please list any surgeries, traumas, accidents or other conditions not previously listed.