Medical Evaluation History

Name_____ Date _____

Present Condition

Date of Accident _____ Injury _____ or Last Flare-up _____

When did your symptoms first appear?_____

Describe incident _____
_____
_____

What activity were you doing when injured**? (Circle or Check)**

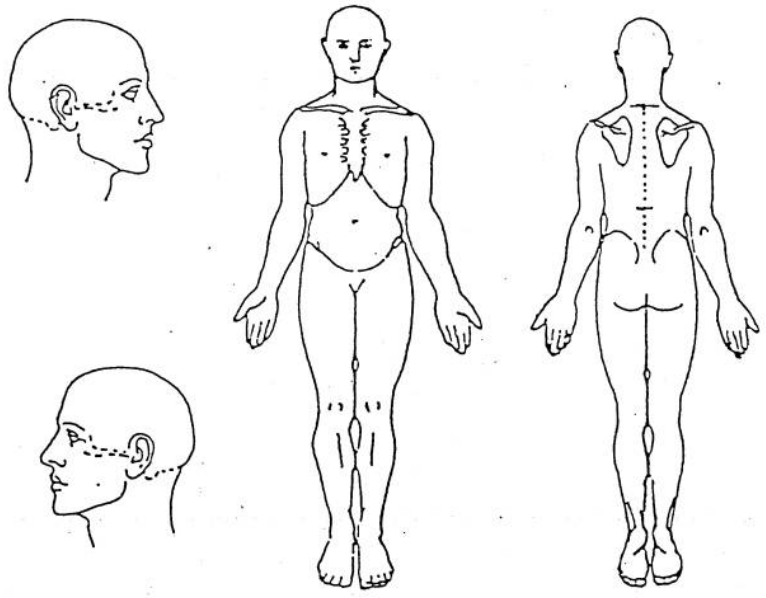
Driving Bending/Lifting How much Weight?_____
Sitting Other Activity_____

Did you feel pain immediately YES / NO Were you in shock? YES / NO
Since your initial onset of symptoms has it gotten Worse Better Same
Did you use Ice? Y / N Heat? Y / N Take Medication Y / N Type_____
If so, what has helped?_____

Mark Area On Body With Initial

Pain Description (**Circle All That Apply**)

Burning	B	Stiff
Deep Dull Ache	D	Tight
Sharp Shooting	SS	Achey
Numbness	N	Throbing
Weakness	W	



Pain Scale

One Week After Injury

1 5 10
I_____I_____I
mild moderate severe

Currently

1 5 10
I_____I_____I
mild moderate severity

What makes your symptoms worse and how long before pain begins?
(Please Check)

	Activity	How Long?
Sitting	_____	_____
Standing	_____	_____
Walking	_____	_____
Bending	_____	_____
Driving	_____	_____
Activities	_____	_____

What eases your pain?

Positions:

Back lying _____ Movement _____

Side lying _____ Stretching _____

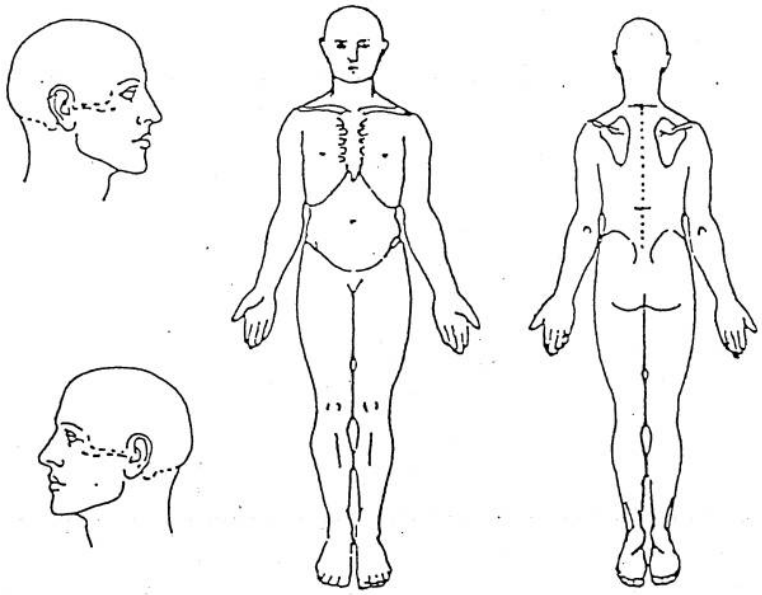
Other _____

PAST MEDICAL HISTORY - List **ALL** you can remember

	Year	Area Injured
Previous Accidents, Falls Or Injuries	_____	_____
	_____	_____
	_____	_____
	_____	__

Did your current pain begin after any of the above l

Do you have any other diagnosed problems? _____



Activity Levels:

Current activities/exercise you partake in outside of

Activity	How many tir
_____	_____
_____	_____

Previous activities that you would like to resume __

Do you sit at a desk most of the day? Y / N

Do you belong to a health club or gym? _____

Does the pain keep you from working out? _____

Are there any activities at work that increase you pain or discomfort? Phone Computer

Do you constantly have to shift positions to find comfort at work sitting or driving? Y / N

Stress Levels: Current Mild Mod Extreme

Any recent major life events (ie. divorce, death, etc)_____
_____

Please Check or Circle if you have ever had

Diabetes	High Blood Pressure	Heart Condition
Cancer	Arthritis	Neurological Disorder (MS/ ALS)
Fractures	Head Injury	Headaches
Dizziness	Difficulty walking	Bowel or Bladder changes
Night pain	Ulcers/ Stomach ailments	Circulation/Vascular problems
Loss of Balance	Infectious Disease	Shortness of breath
Vision loss	Hearing Loss	Chest pain
Difficulty sleeping		

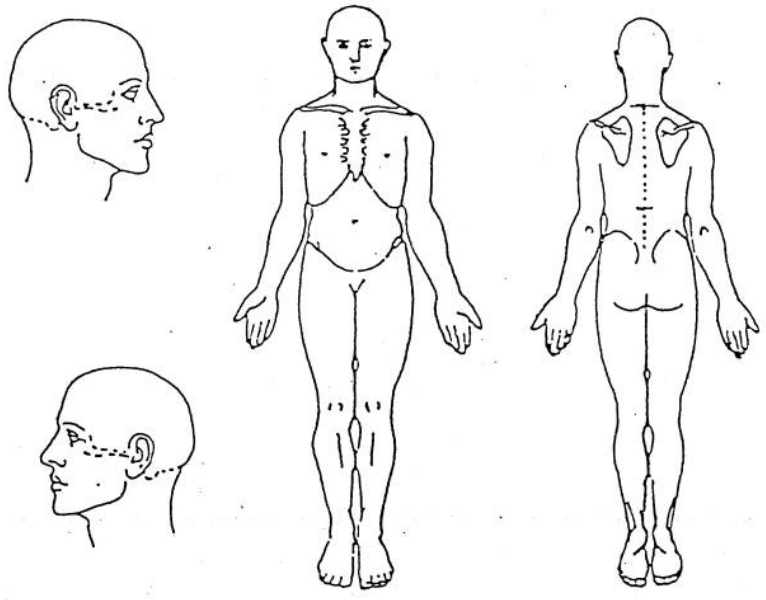
Medications currently taking: For what condition

_____ _____
_____ _____

Steroids History Type of Steroid Date
Injection or _____ _____
Inhalant _____ _____

Surgery History Surgery

_____
_____



Have you received any previous Physical Therapy,

When? _____ How Long?_____ Did y

What goals do you want to achieve through Physica

_____
_____
_____