

ADVANCED PHYSICAL THERAPY, P.C.

INITIAL EVALUATION SHEET

Please check any of the following procedures you are currently or have previously received for this problem:

	Previously	Currently		Previously	Currently
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>
ASTM	<input type="checkbox"/>	<input type="checkbox"/>	MRI	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	CT Scan	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>	EMG	<input type="checkbox"/>	<input type="checkbox"/>
Massage Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>
Splints/Braces	<input type="checkbox"/>	<input type="checkbox"/>	None	<input type="checkbox"/>	<input type="checkbox"/>
Injections	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

Please rate your current pain, on a scale of 0 -10.
(0 represents NO pain, and 10 is UNBEARABLE)

AT REST	NO PAIN	0	1	2	3	4	5	6	7	8	9	10	UNBEARABLE
DURING ACTIVITY	NO PAIN	0	1	2	3	4	5	6	7	8	9	10	UNBEARABLE

What is the frequency of your pain? Constant 4 times daily 1-3 times a day
 4 or more times a week 1-3 times a week No pain

What is your functional ability as it pertains to your job or activity?

- Full functional ability
- Able to function, but with restrictions
- Able to function with no restrictions, but with braces/splints
- Able to function with restrictions, but with braces/splints
- Not able to function/off work or unable to participate in sports

Therapist use only:

PATIENT NAME: _____

Date of Birth: _____