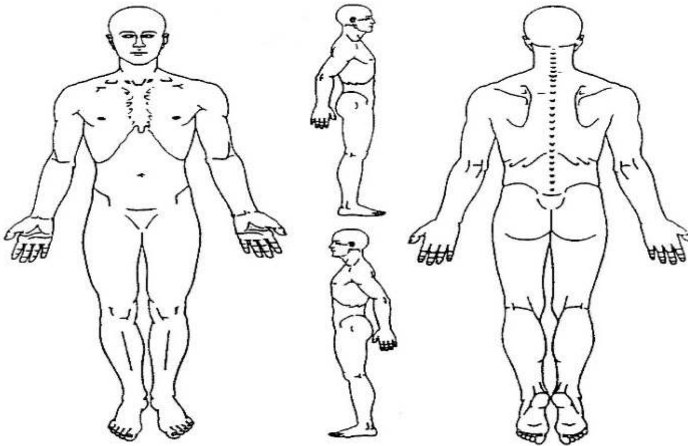
Patient Self Evaluation

Name: ________________________ Age: ______ Referring Physician: ______________________ Date: _______________

- Did you have surgery? Yes/ No Date of surgery: _____________ Follow up appointment w/Physician:____________
- What kind of exercise/occupation do you currently participate in? ____
- Past surgical history____
- Do you have any of the following symptoms or health problems? (Circle all that apply)

High Blood Pressure	Heart problems	Diabetes
Unexplained weight gain or loss	Stumbling or falling	Dizziness
Difficulty urinating	Numbness in groin area	Asthma
Numbness or Tingling in both hands and/or legs	Osteoporosis	

- Please mark the location and type of problem (i.e. tingling, numbness, ache, weakness, sharp/dull, deep/superficial)



Therapist Use Only

Ht: ____ Wt: ____BMI: ____

HR: ________ BP: ________

O2: ________ Temp: ________

- What activities or positions make you feel **WORSE**? ____
- What activities or positions make you feel **BETTER**? ____
- Does ice, heat or medications make you feel better? Yes / No
  If so, which do you use? ____ How Often?__________________
- Are you currently or have you taken steroidal medications or anticoagulants (i.e. Prednizone or Coumadin)? Yes / No
- What Medications, if any, are you currently taking? ____
- Is there a time of day in which you feel better or worse? Yes / No
  If so, please mark the appropriate line:

I feel **BEST** in the …	MORNING	MID DAY	NIGHT
I feel **WORSE** in the…	MORNING	MID DAY	NIGHT

- Does the problem wake you up at night? Yes / No
  If so, how often? _______________________ How long does it take you to return to sleep? ______________________
- Have you ever seen a Physical Therapist for THIS problem? Yes / No
  If so, by whom? ___________________________ Did it help? ____
- Have you had recent X-rays, MRI or other special tests? Yes / No
  If so, what were the results? ____
- What is your primary goal for Physical Therapy? ____