

INITIAL EVALUATION CLINICAL HISTORY FORM

DATE: _____

THERAPIST: _____

PATIENT INFORMATION

NAME _____
 (LAST) (FIRST)

PATIENT # _____

HEIGHT _____ WEIGHT _____

CURRENTLY WORKING? YES NO NOT WORKING SINCE _____

JOB TASKS _____

LEISURE ACTIVITIES _____

REHAB INFORMATION

1. DESCRIBE THE **REASON** FOR YOUR VISIT? _____

2. HOW **LONG** HAVE YOUR SYMPTOMS BEEN PRESENT? _____

3. HOW DID THE PROBLEM **OCCUR**? _____

4. HAS YOUR CONDITION BEEN GETTING? **BETTER** **UNCHANGING** **WORSE**

5. WHAT DECREASES/MAKES YOUR CONDITION **BETTER**? _____

6. WHAT INCREASES/MAKES YOUR CONDITION **WORSE**? _____

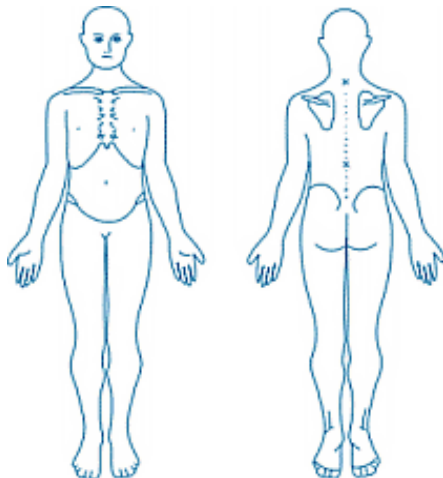
7. LIST ANY TESTS, IMAGING, INJECTIONS, SURGERIES, HOSPITALIZATIONS OR OTHER **MEDICAL TREATMENT** YOU HAVE RECEIVED FOR YOUR **CURRENT CONDITION**

DATE	TREATMENT/SURGERY/HOSPITALIZATION
_____	_____
_____	_____

8. CHECK **ALL THAT APPLY** TO YOUR **CURRENT CONDITION**

- | | |
|---|---|
| <input type="checkbox"/> NUMBNESS/TINGLING/BURNING OF ARMS/HAND | <input type="checkbox"/> NUMBNESS/TINGLING/BURNING OF LEGS/FEET |
| <input type="checkbox"/> HEADACHE | <input type="checkbox"/> BLURRED VISION |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> NAUSEA/VOMITING |
| <input type="checkbox"/> DISTURBED SLEEPING | <input type="checkbox"/> WEAKNESS |
| <input type="checkbox"/> BOWEL/BLADDER CHANGES | <input type="checkbox"/> UNEXPLAINED WEIGHT LOSS |
| <input type="checkbox"/> NIGHT PAIN | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> FEVER/CHILLS/SWEATS | |

9. FRONT BACK



DRAW IN AREAS OF PAIN ON BODY DIAGRAMS USING APPROPRIATE SYMBOLS:

- | | |
|-------------------|------------|
| SEVERE PAIN | ***** |
| MODERATE PAIN | 0000000000 |
| DULL ACHE | ~~~~~ |
| RADIATING PAIN | ↓ ↑ |
| NUMBNESS/TINGLING | XXXXXX |

10. WHAT WOULD YOU LIKE TO BE **ABLE TO DO AT THE CONCLUSION OF THERAPY** THAT YOU ARE CURRENTLY UNABLE TO DO/GOALS FOR THERAPY? _____

11. SOME OF THE FOLLOWING WORDS BELOW DESCRIBE YOUR **PRESENT PAIN**. **LEAVE OUT** ANY CATEGORY THAT IS NOT SUITABLE. USE ONLY A **SINGLE WORD** IN EACH APPROPRIATE CATEGORY – THE ONE THAT APPLIES BEST. CIRCLE **ONLY** THOSE WORDS THAT BEST DESCRIBE IT.

1.
FLICKERING
QUIVERING
PULSING
THROBBING
BEATING
POUNDING

2.
JUMPING
FLASHING
SHOOTING

3.
PRICKING
BORING
DRILLING
STABBING
LANCINATING

4.
SHARP
CUTTING
LACERATING

5.
PINCHING
PRESSING
GNAWING
CRAMPING
CRUSHING

6.
TUGGING
PULLING
WRENCHING

7.
HOT
BURNING
SCALDING
SEARING

8.
TINGLING
ITCHY
SMARTING
STINGING

9.
DULL
SORE
HURTING
ACHING
HEAVY

10.
TENDER
TAUT
RASPING
SPLITTING

11.
TIRING
EXHAUSTING

12.
SICKENING
SUFFOCATING

13.
FEARFUL
FRIGHTFUL
TERRIFYING

14.
PUNISHING
GRUELING
CRUEL
VICIOUS
KILLING

15.
WRETCHED
BLINDING

16.
ANNOYING
TROUBLESOME
MISERABLE
INTENSE
UNBEARABLE

17.
SPREADING
RADIATING
PENETRATING
PIERCING

18.
TIGHT
NUMB
DRAWING
SQUEEZING
TEARING

19.
COOL
COLD
FREEZING

20.
NAGGING
NAUSEATING
AGONIZING
DREADFUL
TORTURING

ADMINISTRATIVE USE (DO NOT COMPLETE) Pain Score = _____

12. HAVE YOU **FALLEN** IN THE PAST 12 MONTHS? **YES** **NO**

IF YES, HOW MANY TIMES? _____ WERE YOU **INJURED**? **YES** **NO**

MEDICAL INFORMATION

1. **CHECK ALL** OF THE **OVER THE COUNTER MEDICATIONS** YOU HAVE TAKEN IN THE **PAST WEEK**

- ASPIRIN TYLENOL/ACETAMINOPHEN ADVIL/MOTRIN/ALEVE/IBUPROFEN
 LAXITIVES DECONGESTANTS ANTACIDS
 VITAMINS/MINERALS/SUPPLEMENTS ANTIHISTAMINES OTHER _____

2. LIST ALL **PRESCRIPTION MEDICATIONS** with **DOSEAGE** YOU ARE CURRENTLY TAKING _____

3. LIST ALL **ALLERGIES** _____

4. HOW WOULD YOU DESCRIBE YOUR **GENERAL HEALTH**? **GOOD** **FAIR** **POOR**

5. DATE OF **LAST PHYSICAL EXAM**: MONTH _____ YEAR _____ PHYSICIAN _____

6. SYSTEMS REVIEW

HAVE YOU HAD OR DO YOU EXPERIENCE? (Check **ALL** that apply)

Cardiovascular system	YES	NO	GI System	YES	NO
Elevated cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Sweating associated with pain	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice (yellow appearance)	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of extremities	<input type="checkbox"/>	<input type="checkbox"/>	Specific food intolerance	<input type="checkbox"/>	<input type="checkbox"/>
History of smoking	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Orthopnea (difficulty breathing)	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Change in color of stool	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Liver problems	<input type="checkbox"/>	<input type="checkbox"/>
GU System	YES	NO	Endocrine System	YES	NO
Dysuria (painful urination)	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Hematuria (blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>
Frequency of urination	<input type="checkbox"/>	<input type="checkbox"/>	Polyuria (large volume of urine)	<input type="checkbox"/>	<input type="checkbox"/>
Urinary urgency	<input type="checkbox"/>	<input type="checkbox"/>	Excessive sweating	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Dysmenorrhea (painful menstruation)	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Post menopausal vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Painful intercourse	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
History of STD	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal System	YES	NO
Date of last period	_____ / _____ / _____		Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Neurological system	YES	NO	Other Arthritic Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Ataxia (poor muscular coordination)	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary System	YES	NO
Memory lapses	<input type="checkbox"/>	<input type="checkbox"/>	Dyspnea (labored breathing)	<input type="checkbox"/>	<input type="checkbox"/>
Confusion	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Head trauma	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged cough	<input type="checkbox"/>	<input type="checkbox"/>
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	Sputum production	<input type="checkbox"/>	<input type="checkbox"/>
Neurological disorder	<input type="checkbox"/>	<input type="checkbox"/>	Amount/color: _____		
Slurred speech patterns	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Hearing/visual disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Other	YES	NO	Other	YES	NO
ENT (ears, nose, throat)	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/Depression	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (skin)	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency/Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency/Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>			

If YES please describe _____

THERAPIST SIGNATURE

DATE