TheraPhysical
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PATIENT INFO

Last Name _____ First Name_____ Age ____ Male ____ Female _____

Occupation _____ Phone _____

IN ORDER TO EVALUATE YOUR CONDITION FULLY, PLEASE BE AS ACCURATE AS POSSIBLE

1. Have you had physical therapy before? _____ No _____ Yes: when _____
2. Where is your pain/ injury? _____
3. What caused your pain/ injury? _____
4. Approximately when did the pain/ injury start? _____
5. Is the pain/injury getting? _____ Worse _____ Better _____ Staying the same
6. Have you ever had this pain/injury before? _____ No _____ Yes: when _____
7. Is your pain? _____ Constant(never goes away) _____ Intermittent (comes and goes)
8. On a scale from zero to ten, circle your worst pain level in the past couple of days 0 1 2 3 4 5 6 7 8 9 10
9. Are you taking any medication for this pain/injury? _____ No _____ Yes: what kind, does it help _____
10. Are any of your usual everyday activities affected? _____ No _____ Yes: describe how _____
11. List all past surgeries with dates _____
12. List all medical conditions you have _____
13. Medical History _____
14. Weight _____ Height _____
15. Medication List _____

Patient Signature _____ **Date** _____

INITIAL EVALUATION

Physical Therapist _____ **Initials** _____ **Date** _____