

Patient Self-Assessment Summary

Name: _____ Age: _____ Employment: _____

Do you have a Latex allergy? YES No Contact Phone number: _____

Have you fallen in the last 3 months? Yes No Emergency Phone number: _____

Have you had Physical Therapy within the past 12 months? _____ If yes, Where _____

Chief complaint: _____

When did you symptoms begin? _____

What activities do you have difficulty performing? _____

Do your symptoms interfere with your work? No Yes _____

Does your pain awaken you from your sleep that is not caused by movement? No Yes _____

Do you have pain with coughing or sneezing? No Yes Do you have pain in the morning? No Yes

What makes your symptoms Worse? _____ Better? _____

Is your pain constant? No Yes MRI date, if applicable: _____ X-ray date, if applicable _____

Surgical date, if applicable: _____

Please list current medicines: _____

Past medical history:

Please select any past medical history that applies to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis (Osteo/Rheumatoid) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Psychological _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bone/fractures |
| <input type="checkbox"/> Balance deficits | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Allergies: _____ |
| <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Heart/Circulation | <input type="checkbox"/> Drug Allergy/Sensitivity |
| <input type="checkbox"/> Recent weight loss with no reason | <input type="checkbox"/> Seizures | _____ |

Any medical conditions not listed: _____

Any hospitalizations/surgical history: _____

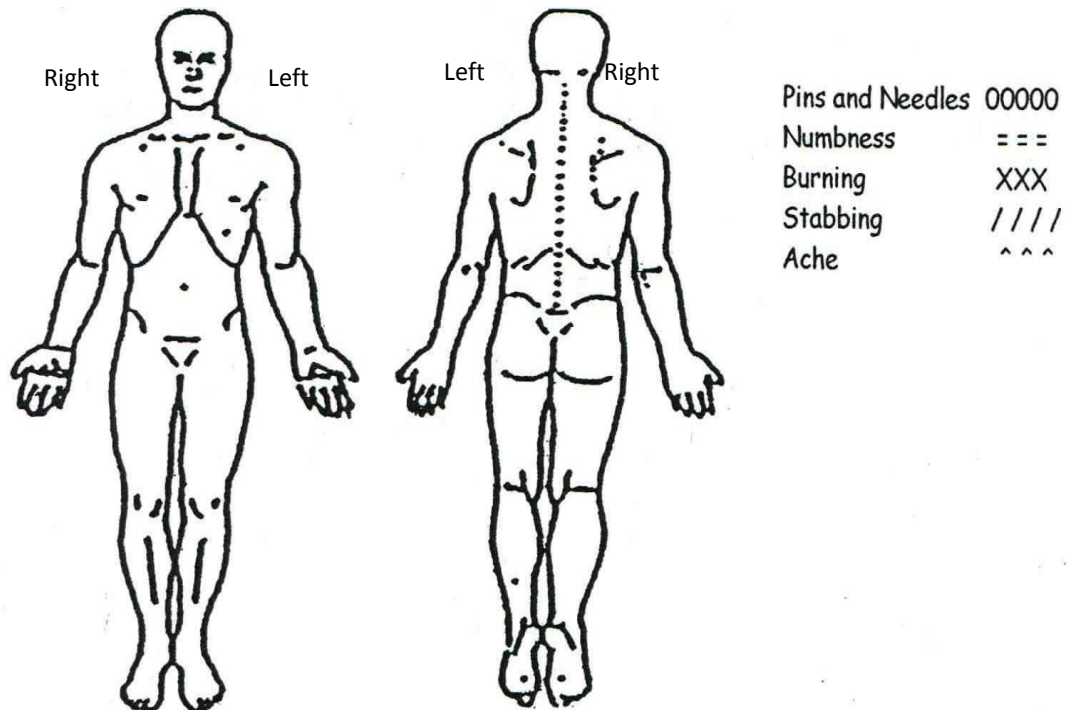
Other information: Goals for Therapy _____

Do you have religious or cultural belief(s) that might impact how we deliver your care? No Yes _____

_____	_____	_____	_____	_____
Patient Signature	Date	Therapist Signature	Date	Time

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Draw the area of your pain on the diagram below. Use the symbols to show your particular types of pain.



Answer each question below. Circle the number that most describes your level of pain.

0 = No pain. 5 = Moderate amount of pain. 10 = Immediately need to go to the hospital.

Which describes your pain right now? 0 1 2 3 4 5 6 7 8 9 10

Which describes your pain at its best? 0 1 2 3 4 5 6 7 8 9 10

Which describes your pain at its worst? 0 1 2 3 4 5 6 7 8 9 10

Patient Signature

Date

Therapist Signature

Date

Time