LIGHTHOUSE Physical Therapy LLC

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Today's Date: _____

INITIAL EVALUATION

Patient Name: _____ Date of Birth: _____ / _____ / _____

Describe Your Current Problem and How It Began: _____

_____

Onset date/Surgery date _____ Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Please list below the main complaints/challenges you have in order of their importance:

1. _____
2. _____

How often are your symptoms present?

☐ Constantly *(76-100% of the day)* ☐ Frequently *(51-75%)* ☐ Occasionally *(26-50%)* ☐ Intermittently *(0-25%)*

Describe the nature of your pain: ☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

How is your condition changing? ☐ Getting better ☐ Not changing ☐ Getting worse

In the past week, how much has your pain interfered with your daily activities:
(Example: work, social activities or household chores)?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Interference **Unable to carry on any activities**

Check if you have difficulty: ☐ Seeing ☐ Hearing ☐ Talking ☐ Memory ☐ Swallowing

What is your most effective learning method: ☐ Seeing ☐ Hearing ☐ Talking ☐ Pictures

Rate your overall health right now: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Have you had x-rays, MRI, CT scan for your area(s) of complaint? ☐ Yes ☐ No

Date(s) taken _____ What areas were taken? _____

Please check all of the following that apply to you:

☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Currently Pregnant, # Weeks _____
☐ Dizziness/Fainting
☐ Numbness (Location) _____
☐ Pain at Night
☐ Pain Unrelieved by Position or Rest
☐ Recent Fever
☐ Urinary Problems

☐ Recent Surgeries _____

☐ Current Medications _____

_____

☐ Other Health Problems *(Explain)* _____

(OVER)

Who have you seen for your condition before today? ☐ No one

☐ Medical Doctor ☐ Massage Therapist ☐ Chiropractor ☐ Physical Therapist

☐ Speech Therapist ☐ Acupuncturist ☐ Occupational Therapist ☐ Athletic Trainer

What treatment did you receive and when? _____

What is your occupation? _____

Please indicate below what makes your symptoms worse:

☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Driving ☐ Running

☐ Bending ☐ Reaching ☐ Lifting ☐ Kneeling ☐ Other

Please indicate below what makes your symptoms decrease:

☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Driving ☐ Running

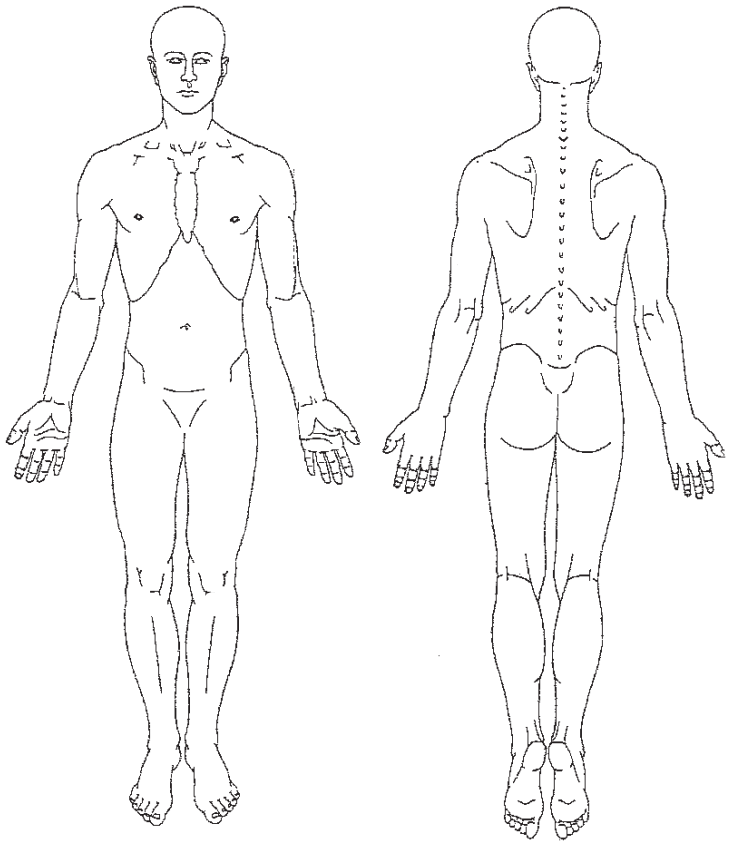
☐ Bending ☐ Reaching ☐ Lifting ☐ Kneeling ☐ Other

Is the pain/discomfort worse in: ☐ Morning ☐ Afternoon ☐ Night ☐ All day

Using the diagrams below ***please circle or shade*** the areas of your body where you feel pain/discomfort and a rating to each area using the scale below.

	No Pain										**Unbearable**
At Best	0	1	2	3	4	5	6	7	8	9	10
At Worst	0	1	2	3	4	5	6	7	8	9	10

FRONT **BACK**



LEFT **RIGHT**