Wholistic Physical Therapy, P.C.

INITIAL EVALUATION SUBJECTIVE REPORT

Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Occupation _____

Age _____ Height _____ Weight _____

Date of Birth _____ SSN _____

How did you hear about us? _____

Referring Physician or Therapist _____

_____

Address _____

Phone_____

The following is very important in our evaluation process.
Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

1. What is the primary complaint that brings you to WPT today?

Secondary complaint?

As a result, I am now having difficulty with:

Are you currently experiencing pain as a result of these symptoms? _____

2. When and how did your symptom(s) begin? Date: _____

_____

3. Have you ever received the following treatment for this condition?

	Yes	No	How long?	Helpful?
Physical Therapy	___	___	_____	_____
MFR	___	___	_____	_____
Chiropractic	___	___	_____	_____
Other	___	___	_____	_____

4. Check the box if you have had any of the following medical conditions?

_____ Diabetes	**_____ Varicose veins**	**_____ Neurological problems**
_____ Rheumatic fever	**_____ Circulatory problems**	**_____ Stroke**
_____ Heart Murmur	**_____ Lung disease**	**_____ Broken bones (fracture)**
_____ High blood pressure	**_____ Epilepsy/seizures**	**_____ Kidney disease**
_____ Heart disease/pacemaker	**_____ Malignancy**	**_____ Liver disease**
_____ Migraine headaches	**_____ Arthritis**	**_____ Metal implants**
_____ Osteoporosis	**_____ Pregnancy**	**_____ Blackouts**
_____ Weight change	**_____ Other: explain**	**_____**

_____

5. List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.

_____

_____

_____

_____

6. List ALL medications which you are currently taking, the problem for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).

Medication	for treatment of	Dose/Amt. per day	Effectiveness

_____

_____

_____

_____

_____

7. Do you have any skin or medication allergies? Yes_____ No _____
If so, which? _____
_____

8. Is there a chance you may be pregnant at this time? Yes___ No _____

9. Do you smoke? Yes___ No____ cigar/cigarettes/pipe How much? _____
When did you quit? _____
_____

10. Please place an "M" in front of each item that you experience at least MONTHLY. Place a "W" in front of each item that you experience WEEKLY or more frequently.

_____ Headaches
_____ Chest pain, tightness
_____ Sweaty palms
_____ Excessive perspiration
_____ Can't keep warm enough

_____ Coughing
_____ Stuffy nose, congestion
_____ Nosebleeds
_____ Earache or ringing noise in ears
_____ Common colds
_____ Sore throat
_____ Asthma or shortness of breath
_____ Hay fever or allergies
_____ Sore, aching muscles
_____ Stiff or tender joints
_____ Back problems
_____ Trembling/twitching muscles
_____ Skin rashes, eruptions
_____ Grinding of teeth (TMJ)
_____ Dry mouth
_____ Mouth sores

_____ Difficulty falling asleep
_____ Difficulty sleeping through night
_____ Awaken too early in morning
_____ Excessive drowsiness during day
_____ Periods of extreme fatigue

_____ Feeling inadequate/unable to cope
_____ Feeling guilty or like a failure
_____ Numbness, tingling in arms or legs
_____ Uncontrolled crying or sadness
_____ Easily annoyed or irritated
_____ Free-floating anxiety about life
_____ Blushing/flushed face

_____ Eyestrain or discomfort
_____ Eyes irritated or inflamed
_____ Visual disturbances - blurry
_____ Stomach cramps
_____ Heartburn/indigestion
_____ Nausea or vomiting
_____ Frequent urination
_____ Incomplete urination
_____ Painful urination
_____ Urinary leakage
_____ Bowel leakage
_____ Diarrhea
_____ Constipation
_____ Bowel irregularity
_____ Frequent laxative use
_____ Uninterested in sex relations

_____ Unable to enjoy sexual activity
_____ Menstrual difficulties
_____ Pre-menstrual syndrome
_____ Breast tenderness
_____ Hot flashes

_____ Feeling faint or dizzy
_____ Feeling tense or nervous
_____ Difficulties with family or friends
_____ Worrisome thoughts
_____ Recurring bad thoughts
_____ Thoughts of suicide
_____
_____ Fearful of persons or places
_____

_____ Water retention
_____ Over-eating, bingeing
_____ Lack of appetite
_____ Excessive alcohol abuse
_____ Other substance abuse
_____ Other: _____

_____

11. Please rate the intensity of your pain with "0" being no pain, "5" being moderate pain, and "10" being unbearable pain.

Your *Pain Intensity* Rating: _____

12. Please rate the frequency of your pain with "0" being never, "5" being intermittent, and "10" being constant.

Your *Pain Frequency* Rating: _____

13. More specifically, rate your pain using the same "0" to "10" scale.

At its worst _____
At its best _____
Most of the time _____
Night (sleeping) _____

14. At what time of day are your symptoms the worst? _____
_____

At what time of day are your symptoms the best? _____
___

15. Do you engage in regular exercise? Yes / No

What type and how often? _____
_____

Are you able to exercise now? Yes / No

Do you have discomfort, shortness of breath, or pain with exercise? _____
___
_____

16. In general, your lifestyle is: **1** **2** **3** **4** **5**
Active **Average** **Inactive**

17. If sleep is a problem, answer these questions:

Do you have trouble falling asleep? **Yes / No**
Is your sleep restful? **Yes / No**
Do you find it difficult to lie down? **Yes / No**
To come to a sitting position from lying down? **Yes / No**

Do you find it difficult to change positions in bed? _____

How many times do you wake in the night? _____

How long before you fall back to sleep? _____

18. What activities increase your pain? _____

What activities decrease your pain? _____

19. Daily Activities

Please estimate the amount of time, *on average*, you spend in each of the following activities <u>per day</u>.

Sleeping _____ **Working** _____

Household Chores _____ **Sitting at desk** _____

Standing in place _____ **Driving** _____

Computer Work _____ **Talking on phone** _____

Playing (specify sports & hobbies) _____

Other _____

How much total time do you tolerate being in a vertical position per day? (e.g. sitting, standing, walking, driving) _____ hour(s)

If you need to rest during the day, how often? _____

And what is the total time? _____ hour(s)

How much total time do you tolerate being in a horizontal position per day? (e.g. reclining, laying down, sleeping) _____ hour(s)

I walk for _____ minutes before needing to rest.

I stand for _____ minutes before needing to sit.

I sit for _____ minutes before needing to change positions/get up.

Do you have trouble getting up from a chair? Yes / No

Do you have trouble putting on your shoes and socks? Yes / No

Do you have difficulty climbing stairs? Yes / No

20. If any daily activities are limited, answer this question.

List all the Tasks/Activities that you have difficulty performing and your tolerance (minutes/hours) for each task/activity. If you are no longer able to perform an activity, your tolerance would be "0".

Task/Activity	Tolerance
1._____	1._____
2._____	2._____
3._____	3._____
4._____	4._____
5._____	5._____

21. Functional Ability

On the line scale below, place a check mark to indicate your level of daily functional ability.

	Inactive	Normal
On a good day	0% _____	100%
On a bad day	0% _____	100%

22. Patient Goals

List the activities that you would like to be able to do as a result of therapy.

Activity	Duration/How Often	By When
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Other Goals? _____

_____

_____