Personalized Therapy, LLC

Occupational & Physical Therapy for Children & Adults

Initial Evaluation History Sheet

Name :	Date:	Age:
Physician:	Diagnosis:	
Occupation/ Activity:		

LEFT RIGHT

Date of injury or surgery

How did you injure yourself? (Circle)

Fall Overuse At Work Sports Unknown

Explain

Have you had this injury before? (Circle) Y N

Have you had physical therapy before? (Circle) Y N

If yes when

Any other medical history (Circle)

Diabetes High Blood Pressure Heart Condition

Cancer Arthritis Osteoporosis

Surgeries Other

Are you taking any medications? (Circle) Y N

Please list them :

Do you have any allergies ? Y N

Please list :

Presently, what is your chief complaint?

Do you have pain? Y N

Where is your pain?

(Circle) for the following

Your Pain Level None 1 2 3 4 5 6 7 8 9 10 worst

Pain Frequency Intermittent Constant

Type of Pain Sharp Dull Burning

Do you have stiffness? Y N

Do you have swelling? Y N

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Are you able to work right now?	Y	N
Are you able to enjoy your hobbies or sports?	Y	N

Please circle all activities that are difficult at this time:

Dressing	Brushing Teeth	Sleeping through the night
Washing your hair	Eating	Sitting (long periods)
Typing	Going up/down stairs	Driving
Lifting	Walking	Standing (long periods)
Throwing	Kneeling	Bending
Other:	Other:	Other:

Right now, I feel I am getting (circle)

Better Worse Staying the same

(For therapist use only)

Patient Signature:	Date: