

PERSONALIZED THERAPY, LLC- INITIAL ASSESSMENT

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Medicare Provider#: 262P

GENERAL INFORMATION

NAME: _____ **DOB:** _____ **AGE:** _____ **y.o.** **SOC/EVALUATION DATE:** _____
PHYSICIAN: DR. _____ **SEX:** **Male** **Female** **TYPE OF EVAL:** **PT** **OT** **ADULT** **PED**
SUBJECTIVE: Presently what is your Chief Complaint? : _____
MEDICAL DIAGNOSIS: _____ **TREATMENT DIAGNOSIS:** Same / _____

PATIENT HISTORY/ SUBJECTIVE- Circle all that applies

PAST MEDICAL HISTORY: Diabetes Cancer High Blood Pressure Heart Condition Arthritis Osteoporosis Surgeries

Other/Explain: _____

Medications: None / See Additional List Provided Please list : _____

Allergies: None / Please list : _____

Current and/or prior Treatment: No / Yes Physical Occupational Speech From _____ Through _____

How did you injure yourself? Fall Overuse At Work Sports Other Explain: _____

Date of Injury/Onset: _____ **Have you had this injury before?:** No / Yes When: _____

Prior Hospitalization: No / Yes From _____ Through _____ **Name of Hospital/SNF:** _____

Prior Level of Function (before injury/onset) : Independent Required Assistance

Explain Assistance Need : _____

Activities that are difficulty at this time Activities of Daily Living (ADL) / Recreational Activities:

Dressing Grooming Bathing Washing hair Eating Sleeping through the night Sitting (long periods)

Standing (long periods) Lifting Walking Bending Throwing Kneeling Bending Household mobility Community Mobility

Other: _____

Occupation: _____ **Are you working?** Y / N **Job duties that are difficult:** _____

Hobbies/Sports/Interests: _____

PAIN- Circle all that applies

LOCATION: N/A _____ **Describe:** Constant Intermittent Sharp Dull Burning Radiating

RATE: None 1 2 3 4 5 6 7 8 9 10 Worst At best _____ At worst _____

Aggravating Activities: Sleep Bending Squatting Lifting Reaching Driving Walking Sitting Standing

Relieving Activities: Medications Hot pack Cold pack Rest Activity: _____ Other: _____

Please sign here to verify information: _____

FOR THERAPIST USE ONLY: Therapist Notes: _____

Patient Name: _____ **DOB:** _____ **Page 1 of Eval**