KGD-PT Outpatient Initial Evaluation

In order to thoroughly assess you, please take the time to fill the below out as accurately as you can. Thank you!

Name: _____

1. **Gender**: ❑ Male ❑ Female
2. **Height**: _____ **Weight**: _____
3. **Are you** ❑ Right Handed or ❑ Left Handed
4. **Cultural/Religious**
   Any customs or religious beliefs or wishes that might affect care? _____
5. **Current Condition**(s) **Chief Complaint**(s)
   Describe the problem(s) for which you seek physical therapy. _____

   _____

   _____

   On a scale below circle your worst pain level in the past couple of days:

   Mild *Moderate* *Severe*
   0 1 2 3 4 5 6 7 8 9 10

   When did the problem(s) begin (date)___/____/___

   What happened?_____

   _____

   _____

   Have you ever had the problem(s) before? Y / N

   What did you do for the problems? _____

   _____

   _____

   Did the problem(s) get better? Y / N

   About how long did the problems last?

   _____

   _____

   What makes the problem(s) better?

   _____

   _____

   What makes the problem(s) worse?

   _____

   _____

   Have you had physical therapy before? Y / N
   for how long? _____

   Are you under the care of a chiropractor and/or acupuncturist? _____

   Are any of your usual everyday activities affected? (bed mobility, transfers, walking, stairs, self care, household chores, work activities) Y / N
   how _____

   _____

   What are your goals for physical therapy?

   _____

   _____

   _____

6. **Occupation:**_____
7. **Do you use a:** ❑ cane walker, ❑ hearing aids, ❑ dentures, ❑ pacemaker, ❑ glasses, ❑ contact lenses, ❑ other _____
8. **General Health Status**: ❑ Good ❑ Fair ❑ Poor
9. **Social/Health habits:**
   do you smoke? Y / N # of cigarettes _____
   pipes _____ cigars _____
   Alcohol: On average how many drinks/week: _____
   Exercise: Do you exercise beyond normal daily activities and chores? Y / N
   Describe the exercise:_____

   _____

10. **List all your past surgeries with dates:**

    _____

    _____

    _____

11. **Please list any medical tests** (MRI, Bone scan etc.)_____

    _____

12. **List all your medical conditions you have or had** (or where told you have):

    _____

    _____

    _____

13. **List all the medications you are on:**

    _____

    _____