Initial Evaluation Subjective Report

Date_____

Name_____

How do you prefer to be addressed?_____

Age_____ Height_____ Weight_____

Occupation_____ Are you currently working?_____ Hours per week_____

How did you hear about us?_____

Referring Physician_____ Referring Therapist_____

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 FUNCTIONAL ABILITY AND SYMPTOMS.

1. Below you will find a list of common activities that patients have difficulty performing because of their symptoms. **For each activity, please note the amount of time in minutes or hours that you can perform the activity before you feel that you need to stop because of your symptoms.** If you have no difficulty with the activity, mark "OK". If you are unable to perform the activity, mark "Unable".

Activity	Tolerance	Activity	Tolerance
Sitting	_____	Computer Work	_____
Standing	_____	Exercise	_____
Walking	_____	Writing	_____
Stairs (# of stairs/ flights)	_____	Shopping	_____
Driving	_____	Bending	_____
Sleeping	_____	Reaching (# of repetitions)	_____
Household Chores		Lifting (# of pounds)	_____
Vacuuming	_____	Carrying (# of pounds)	_____
Cooking	_____	Other	
Laundry	_____	_____	_____
Dish Washing	_____	_____	_____

2. WHAT ARE YOUR GOALS FOR PHYSICAL THERAPY? For example, what activities from the above list would you like to be able to perform better or longer? How long in minutes or hours do you need or want to perform each activity?

3. On the lines below, place a slash mark to indicate your functional ability as a % of normal.

On a good day 0%_____100%

On a bad day 0%_____100%

4. What is your primary complaint that brings you to MFR? Please describe your symptoms as specifically as possible.

Secondary complaint?

5. On what date did your symptoms begin? _____

6. How did your symptoms begin? For example, did your symptoms begin as a result of an accident or trauma, or did they begin without a known reason?

7. Put a slash mark on the line below to rate the INTENSITY of your symptoms:

No pain _____ Worst pain imaginable

Put a slash mark on the line below to rate the FREQUENCY of your symptoms:

No pain _____ Constant pain

8. Do you have any of the following medical conditions?

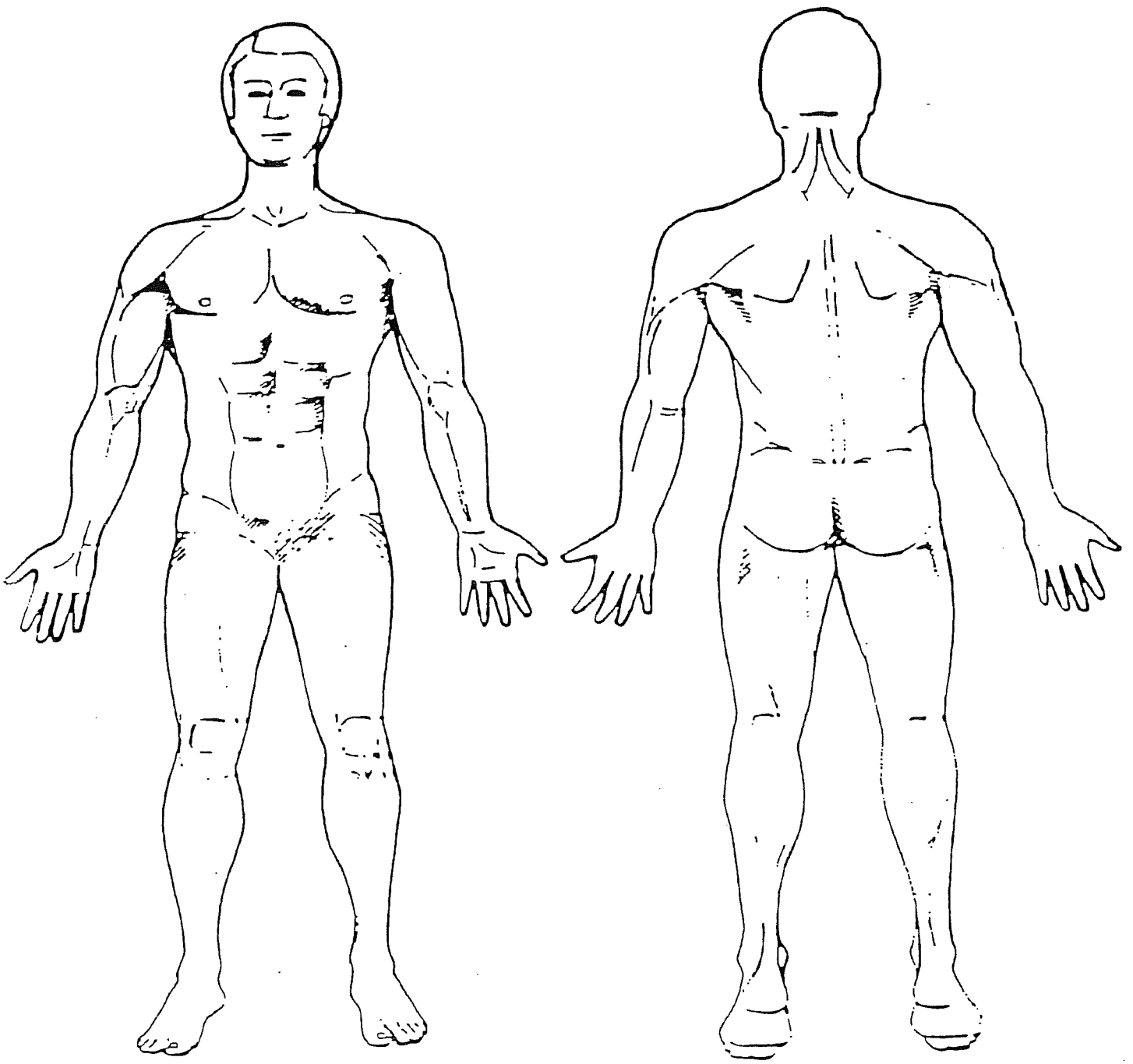
	YES	NO		YES	NO
Circulatory problems	____	____	Blackouts	____	____
High blood pressure	____	____	Visual disturbances	____	____
Heart trouble	____	____	Weight changes (>15lbs.)	____	____
Pacemaker	____	____	Headaches	____	____
Epilepsy	____	____	Ringing in ears	____	____
Diabetes	____	____	Bowel/Bladder Problems	____	____
Pregnancy	____	____	Malignancy	____	____
Stroke	____	____			

9. Past Medical History: Please list any surgeries, traumas, accidents or other conditions and the dates that you have had throughout your life.

10. Have you ever received the following treatment for your current condition?

Treatment	Yes	No	How long?	Helpful?
Physical therapy	___	___	_____	_____
MFR	___	___	_____	_____

LEASE SHADE AREAS OF PAIN ON THE DIAGRAM BELOW:



MEDICATIONS:

Please indicate below ALL medications which you are currently taking, the problem for which you are using them and the dose and their effectiveness:

Medication:	For Treatment of:	Dose / Amt / Day:	Effectiveness: