**Initial Self-Evaluation Form - Flaming Physical Therapy**

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**Patient’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Original Injury, symptoms or Pain: \_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESENT CONDITION / PAIN / SYMPTOMS**:

1. Please Shade or make an “X” in area (or areas) where you are experiencing pain /symptoms.
2. If the symptoms travel/radiate, use an “arrow” to follow the path of pain
3. Feel free to use more than one symbol

 

1. Current Injury/Symptom Descriptors: Circle any/all words that apply, add others

1. When and what initially caused you to seek Physical Therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List symptom(s) that you “INITIALLY” experienced \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	1. Severity Initially: 0 1 2 3 4 5 6 7 8 9 10
2. List Symptom(s) that you “CURRENTLY” experience \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	1. Severity Currently: 0 1 2 3 4 5 6 7 8 9 10
3. Since Initiation, how has the pain changed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial Self-Evaluation Form – Flaming Physical Therapy (Continued)**

1. Since onset have your symptoms become:
	1. BETTER B. WORSE C. No CHANGE
2. How often do you experience the Symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What makes your symptoms Worse?

Sitting Standing Walking Bending Lifting Other

1. What eases your Symptoms

Sitting Standing Walking Bending Lifting Other

1. How much does your pain interfere with your activities?
	1. None (0%) Rarely (1-19%) Often (20-39%)
	2. Moderate (40-59%) Almost always (60-79%) Always (80-100)
2. Are you taking any Medications related to the reason you’re in PT? YES NO
	1. If yes, What and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST HISTORY OF SYMPTOMS**

1. Have you ever had these kinds of symptoms before? YES NO

If Yes, when was the previous episode? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How often have they reoccurred? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Has the frequency of severity of these symptoms increased since that former episode?
	1. FREQUENCY? YES NO B. SEVERITY? YES NO

**PAST MEDICAL HISTORY**

Accidents or injuries? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer? YES NO COPD YES NO

Arthritis YES NO Neurologic Disorders YES NO

Pregnancy? YES NO Parkinson’s YES NO

Immunosuppression? YES NO Pacemaker YES NO

Have you had other related P.T. or Body work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing, I certify that all information in this form is true and correct to the best of my knowledge.

Patient (or Guardian) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_