INITIAL EVALUATION

Date: _____

Name:_____

Referring Doctor:_____

Diagnosis:_____

Other Referral Source:_____

Primary Complaint Today: _____

Date of Injury/ Onset: _____

Circumstances: _____

Surgeries and significant medical history:
_____
_____
_____

Present Medications: _____

Diagnostic tests/ dates/ results: _____

Current treatment/ Provider:
_____
_____

Past treatment/ success of such:
_____
_____

List any activities that are now limited, which you could do in the past:
_____
_____
_____

Are you employed: yes no Where: _____

Occupation:_____ Hours Per Week:_____

Does your work involve (circle):

Sitting (long short n/a) periods of time
Standing (long short n/a) periods of time
Stooping (yes no)
Bending (yes no)
Lifting (yes no) pounds:_____ frequency:_____

FUNCTIONAL ASSESSMENT

Name: _____ Date: _____

Thank you for your time in answering these questions. This helps us to design a treatment plan best suited to your individual needs, to progress the program based on your goals and to help us satisfy third party legal and medical documentation requirements.

Functional Status

Do you live alone? Yes No Do you have a Spouse? Yes No

Number of Children: _____ Age: _____ # at home_____

Current Tolerance Time Tolerated Pain (yes or no) ____Goal___

Walking _____

Standing _____

Sitting _____

Sleeping _____

Are you a student? Yes No Where? _____

Working (Please list tasks involved in your job and your tolerance to them) Good Fair Poor

Activities of daily living	Are you independent?	Comments
Dressing	Yes No	_____
Eating	Yes No	_____
Hygiene	Yes No	_____
Laundry	Yes No	_____
Cooking	Yes No	_____
Yard Work	Yes No	_____
Driving/ Traveling	Time Tolerated	_____
Lifting	Weight Tolerated	_____

Please list cleaning/ household chores that you can/cannot do:

Can Do: _____

Cannot Do: _____

Children Activities: _____

Recreational Activities:

Sports: _____ Times per week:_____

Hobbies: _____ Times per week:_____

Social Activities- Can you enjoy movies, social gatherings? Please describe.

_____
_____
_____

Do you have a current exercise program? If so, what is the frequency and duration of such?

_____
_____

List any previous exercise/activities that you are unable to do now

_____
_____

Diet How would you rate your overall diet? Excellent Good Fair Poor

Based on the above information, what are your treatment goals?

_____
_____
_____
_____