**PHYSICAL THERAPY CENTER**

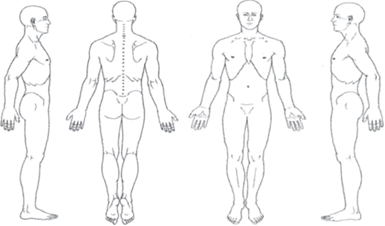
**PATIENT SELF-ASSESSMENT**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ht\_\_\_\_\_\_\_\_ Wt\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your symptoms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did your symptoms begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did they begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Indicate where you have pain or other symptoms**



None Unbearable

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

1. Have you had physical therapy or other treatment for this problem in the past? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_

If yes, where and what were the results of the treatment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. List medications you are currently taking, include over-the counter, homeopathy and vitamins

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1. List past surgeries, serious illnesses or accidents\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Do you a. Consume alcohol \_\_\_\_\_\_\_\_ How many glasses? \_\_\_\_\_\_\_\_

b. Smoke \_\_\_\_\_\_\_\_ How many daily? \_\_\_\_\_\_\_\_

c. Use caffeine or sugar\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_

f. Feel tired often \_\_\_\_\_\_\_\_

8. Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_\_

9. How do you relax?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. List social activities available (treadmill, pool, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. List physical requirements for work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Play\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Please check all that apply to you:

□ High Blood Pressure □ Heart Disease □ Diabetes □ Eyes, Ears, Nose Throat

□ Cancer/Malignancy □ Hormonal Problem □ Headaches □ Genito-Urinary problem

□ Mental/Nervous Disorder □ Irregular Heart Beat □ Gout □ Pain Upper Lower Back

□ Respiratory/breathing problems □ Head, Knees, Ankles, Feet □ Epilepsy □ Other □ Pain Neck Shoulders Hips Jaw □ Ulcer/digestive Disorder □ Chest Pain

□ Reconstructive surgery/implants □ Birth Defect □ Pacemaker

□ Wear shoe inserts, mouth bite, splints/braces

This information is true and accurate to the best of my knowledge at the present time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date