PT Initial Evaluation Subjective Report

Date: _____

First Name: _____ Last Name: _____

How do you prefer to be addressed: _____ Date of Birth: _____

Email Address (to be used for appointment reminders only): _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Contact number (if different than Home phone): _____

Occupation: _____ Currently Working?: _____ Hours week: _____

Referring Physician: _____

How did you find out about us? _____

Have you ever had Myofascial Release before? If so, by whom? _____

THE FOLLOWING IS VERY IMPORTANT IN OUR CLINICAL ASSESSMENT. PLEASE COMPLETE EACH QUESTION AS COMPLETELY AS POSSIBLE TO PROVIDE US WITH A CLEAR PICTURE OF YOUR PRESENT CONDITION AND PAST INJURIES.

1. What is your primary complaint that brings you for treatment? Please describe your symptoms as specifically as possible.

Secondary complaints?

2. On what date did your symptoms begin? _____

3. How did your symptoms begin? (accident, trauma, no known reason, etc)

Symptoms increase with:

4. How have your symptoms changed since they began?

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

No pain _____ **Worst pain imaginable**

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

No pain _____ **Constant pain**

7. Functional Ability:

A. What was your prior functional level/ability prior to your symptom(s)?

B. What functional things are you now unable to perform?

Below is a list of common activities. For each activity **please note the amount of time in minutes or hours that you can perform the activity before you start to have symptoms.** Mark "OK" for the activities you do not have difficulty with. Mark "Unable" for those you can not perform.

Activity	Tolerance	Activity	Tolerance
Sitting/Driving	_____	Standing	_____
Walking	_____	Stairs (# or flights)	_____
Household Chores	_____	Sleeping	_____
Shopping	_____	Exercise	_____
Carrying (pounds)	_____	Other _____	_____

8. 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%**

9. Do you have any of the following medical conditions? (If yes, please explain below)

	YES	NO		YES	NO
Circulatory Problems	_____	_____	Stroke	_____	_____
Blood Clots	_____	_____	Blackouts	_____	_____
High Blood Pressure	_____	_____	Visual disturbances	_____	_____
Heart trouble	_____	_____	Weight changes (>15)	_____	_____
Headaches	_____	_____	Epilepsy	_____	_____
Diabetes	_____	_____	Ringing in ears	_____	_____
Pregnancy	_____	_____	Bowel/Bladder probs	_____	_____
Malignancy	_____	_____	Pacemaker	_____	_____

Explain "Yes's" here:

10. Past Medical History: Please list any surgeries, traumas, accidents or other conditions along with the dates.

11. What are your treatment goals?

12. Have you ever received treatment(s) for you current condition? If so, what kind of treatment, how long, and was it helpful.

Motion For Life
Treatment Release Form

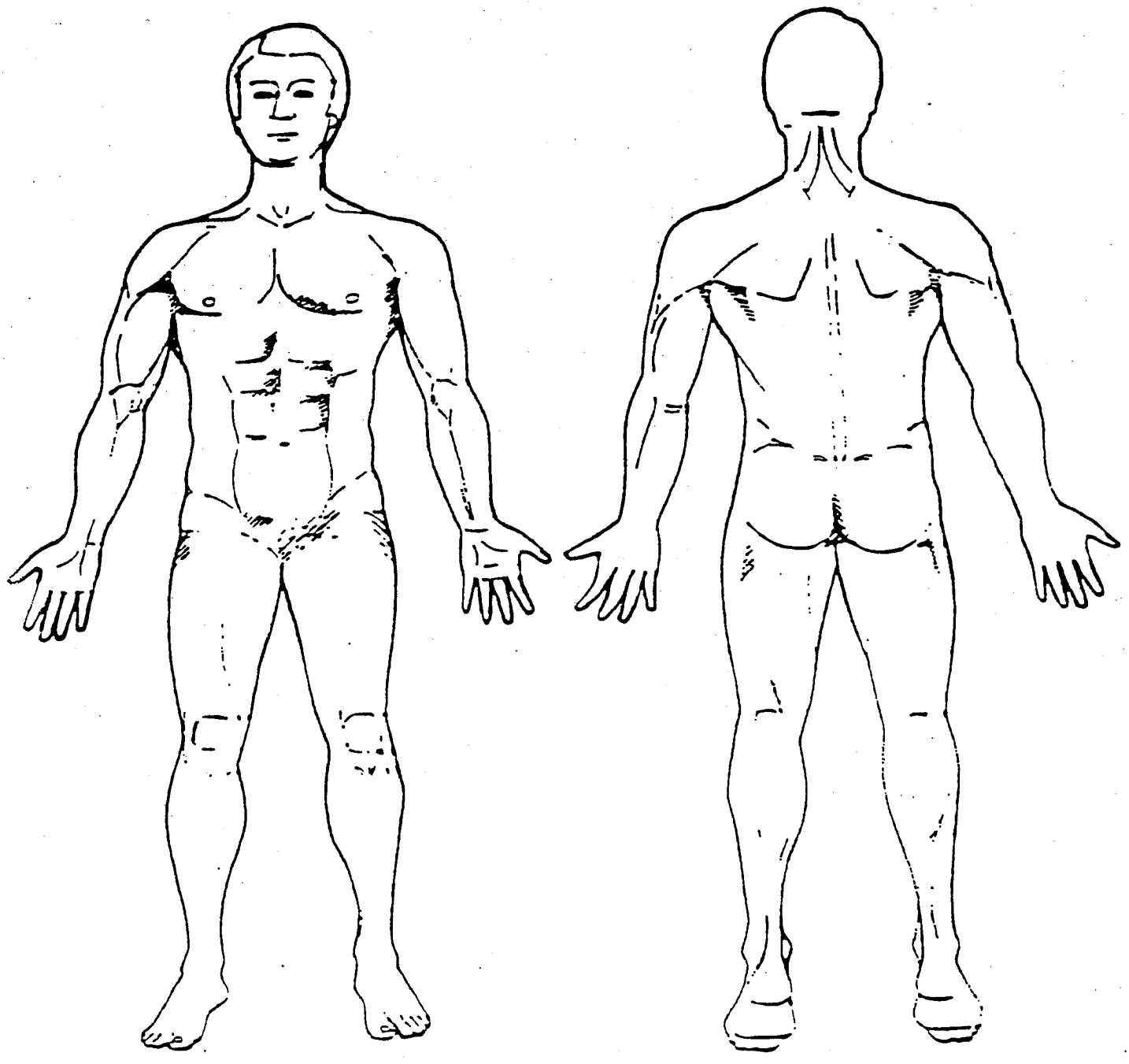
I _____, am in agreement that today's session and future sessions are being provided by a trained Myofascial Release Therapist. I understand that all information gathered for, and during treatment sessions adheres to confidentiality rules defined by HIPAA.

Client Signature: _____ Date:_____

Client Printed Name: _____

Witness: _____

PLEASE SHADE AREAS OF PAIN ON THE DIAGRAM BELOW:



PLEASE PLACE A ✓ IN FRONT OF EACH ITEM THAT YOU EXPERIENCE AT LEAST MONTHLY, PLACE AN **X** IN FRONT OF EACH ITEM THAT YOU EXPERIENCE WEEKLY OR MORE FREQUENTLY.

_____ Headaches (type)
_____ Heart pounding or racing
_____ Irregular heart beat
_____ Chest pain, tightness
_____ Numbness, tingling in arm or leg
_____ Can't keep warm enough
_____ Sweaty palms
_____ Blushing, flushing face
_____ Coughing
_____ Stuffy nose, congestion
_____ Earache or ringing noise in ears
_____ Common colds
_____ Sore throat
_____ Asthma or shortness of breath
_____ Hay fever or allergies
_____ Sore, aching muscles
_____ Stiff or tender joints
_____ Back problems
_____ Trembling / twitching muscles
_____ Skin rashes, eruptions
_____ Grinding of teeth (TMJ)
_____ Dry mouth
_____ Mouth sores
_____ Excessive perspiration
_____ Difficulty falling asleep
_____ Difficulty sleeping through night
_____ Awaken too early in morning
_____ Excessive drowsiness during day
_____ Periods of extreme fatigue
_____ Feeling faint or dizzy
_____ Feeling tense or nervous
_____ Difficulties with family or friends
_____ Worrisome thoughts
_____ Recurring bad thoughts
_____ Thoughts of suicide
_____ Fearful of persons or places

_____ Feeling inadequate / unable to cope
_____ Feeling guilt or failure
_____ Uncontrolled crying or sadness
_____ Easily annoyed / irritated
_____ Free-floating anxiety about life
_____ Voice quivering, shaking
_____ Eyes irritated or inflamed
_____ Vision blurred
_____ Eyestrain or discomfort
_____ Nosebleeds
_____ Stomach cramps
_____ Heartburn – indigestion
_____ Nausea or vomiting
_____ Frequent urination
_____ Incomplete urination
_____ Painful urination
_____ Urinary leakage
_____ Bowel leakage
_____ Gas in lower bowel
_____ Diarrhea
_____ Constipation
_____ Bowel irregularity
_____ Uninterested in sexual relations
_____ Unable to enjoy sexual activity
_____ Unable to participate in sex acts
_____ Menstrual difficulties
_____ Pre-menstrual Syndrome
_____ Breast tenderness
_____ Hot Flashes
_____ Water retention
_____ Over-eating / bingeing
_____ Lack of appetite
_____ Excessive alcohol abuse
_____ Other substance abuse
_____ Frequent laxative use
_____ Other:

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: