



### Initial Evaluation Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Date of Surgery: \_\_\_\_\_

Restrictions or precautions given by your doctor: \_\_\_\_\_

Have you had an x-ray taken for this injury? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had an MRI taken for this injury? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had an injection/shot for this injury? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you been to physical therapy before for this injury? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you been to a chiropractor for this injury? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have legal representation for your injury? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, who? \_\_\_\_\_

What are your goals in physical therapy? What do you wish to accomplish? \_\_\_\_\_

#### **Past Medical History**

Please check any condition that you currently have, or have been diagnosed with in the past.

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Emphysema                  | <input type="checkbox"/> Hernia               | <input type="checkbox"/> Headache        |
| <input type="checkbox"/> Chest Pain       | <input type="checkbox"/> Tuberculosis               | <input type="checkbox"/> Leg Cramps           | <input type="checkbox"/> Fibromyalgia    |
| <input type="checkbox"/> Pacemaker        | <input type="checkbox"/> Shortness of Breath        | <input type="checkbox"/> Depression           | <input type="checkbox"/> Ulcer           |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Incontinence         | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Stroke           | <input type="checkbox"/> Dizziness/Light headedness | <input type="checkbox"/> Circulatory Disorder |  |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis               | <input type="checkbox"/> Currently Pregnant   |  |

Please list ALL surgeries you have had in the past: \_\_\_\_\_

Please list ALL medications (over the counter, prescriptions, and supplements) that you are currently taking:

#### **Do you use an assistive device? (Check all that apply)**

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> Cane         | <input type="checkbox"/> Manual Wheelchair    |
| <input type="checkbox"/> Walker       | <input type="checkbox"/> Motorized Wheelchair |
| <input type="checkbox"/> Other: _____ |   |

#### **With whom do you live? (Check all that apply)**

- Alone
- Spouse/Significant Other
- Child/Children
- Other Relatives
- Group Setting
- Personal Attendant
- Other: \_\_\_\_\_

#### **Where do you live?**

- Private Home
- Private Apartment
- Rented Room
- Boarding / Group Home
- Homeless
- Nursing Home
- Hospice
- Other : \_\_\_\_\_

## Work-Related Questions

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Are you currently working?

Yes

No

What is your duty status?

Regular

Modified

Light

Off

### Employment/Work (check all that apply)

Working full time outside of home

Working part time outside of home

Working full time from home

Working part time from home

Working with modification in job due to illness/injury

Not working due to injury/illness

Homemaker

Student

Retired

Unemployed

Please check all that apply to your work day:

I sit for most of the day.

I am on the phone or computer for most of the day.

I stand for most of the day.

I perform a lot of bending or lifting while at work.

I lift heavy objects.

I drive long distance or spend a long time commuting.

Other: \_\_\_\_\_