INITIAL EVALUATION WORKSHEET **Therapist Name:**

Patient Name (Sex): **Date of Birth (Age Y/O):**

BMI: Low/High/NL **Date of Eval:**

Hand Dominance: □ Right □ Left **Employment (sustain posture):**

Educational level: **Hobbies/ Interests/ Exercise:**

What activities are you having difficulty performing?

Have you had any testing? □ X-rays □ MRI □ EMG/ Nerve Conduction Test □ CT Scan □Other

Results:

Did you have a surgery? □ Yes □ No If Yes, please describe (Date of Surgery):

Have you ever had these symptoms before? □ Yes □ No Description:

Have you ever had treatment before for these symptoms? □ Yes □ No If Yes, please describe:

What activities make your pain WORSE?

What activities make your pain BETTER?

Do you use an assistive device? □ None □ Cane □ Walker □ Wheelchair □ Other:

CC:

Past Hx:

Special Test:

ROM (P,A):

DTR:

Local edema (swelling):

Trophic change (Ulcer, Deformity):

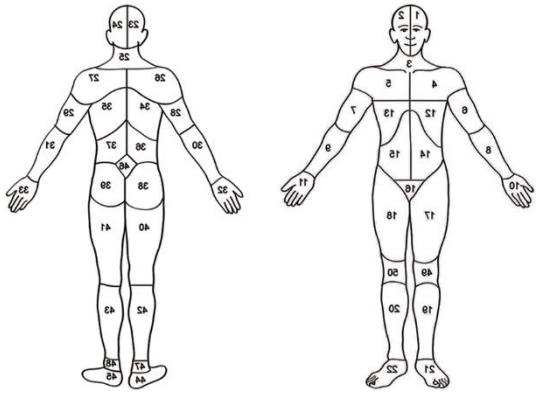
Temp:

General posture:

Sensory integration:

Gait:

Balance:



VAS (0-10):

Are your symptoms: □ Constant □ Come and Go □ Ache □ Deep □ Superficial □Dull □ Sharp □ Shooting □ Burning □ Numbness/Tingling □ Other:

Does your pain seem to be WORSE at a certain time of day? □ Yes □ No If Yes, □ Morning □Night □ Other:

MMT:

Dx:

Plan:

Evaluation after 10 sessions: