Initial Self-Evaluation Form - Flaming Physical Therapy

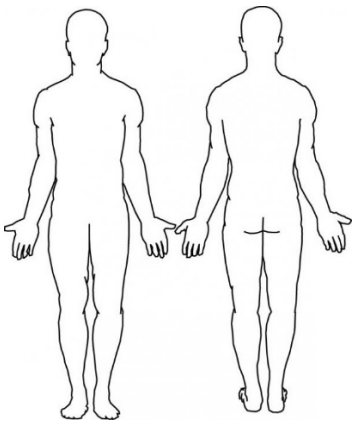
11 Elsinore Avenue, Bath 207-442-9810
68 Chapman Street, Damariscotta 207-563-7990

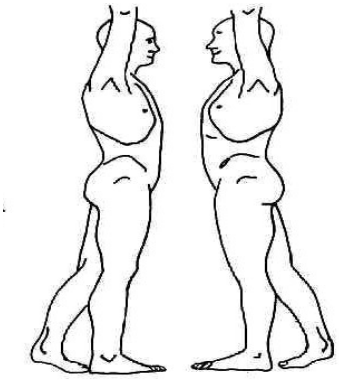
Patient's Name: _____ Date: _____

Date of Original Injury, symptoms or Pain: _____ Date of Birth: _____

PRESENT CONDITION / PAIN / SYMPTOMS:

1. Please Shade or make an "X" in area (or areas) where you are experiencing pain /symptoms.
   a. If the symptoms travel/radiate, use an "arrow" to follow the path of pain
   b. Feel free to use more than one symbol





   c. Current Injury/Symptom Descriptors: Circle any/all words that apply, add others

- Severe
- Moderate
- Numbness
- Tingling
- Weakness

- Dull
- Throbbing
- Aching
- Poor balance
- Stiffness

- Radiating
- Burning
- Stabbing
- Sharp/Searing
- _____

2. When and what initially caused you to seek Physical Therapy? _____
   _____
3. List symptom(s) that you "INITIALLY" experienced _____
   a. Severity Initially: 0 1 2 3 4 5 6 7 8 9 10
4. List Symptom(s) that you "CURRENTLY" experience _____
   a. Severity Currently: 0 1 2 3 4 5 6 7 8 9 10
5. Since Initiation, how has the pain changed? _____

Initial Self-Evaluation Form – Flaming Physical Therapy (Continued)

6. Since onset have your symptoms become:
    a. BETTER B. WORSE C. No CHANGE
7. How often do you experience the Symptoms? _____
8. What makes your symptoms Worse?

Sitting Standing Walking Bending Lifting Other

9. What eases your Symptoms

Sitting Standing Walking Bending Lifting Other

10. How much does your pain interfere with your activities?
    a. None (0%) Rarely (1-19%) Often (20-39%)
    b. Moderate (40-59%) Almost always (60-79%) Always (80-100)
11. Are you taking any Medications related to the reason you're in PT? YES NO
    a. If yes, What and how often? _____

PAST HISTORY OF SYMPTOMS

1. Have you ever had these kinds of symptoms before? YES NO

    If Yes, when was the previous episode? _____
2. How often have they reoccurred? _____

3. Has the frequency of severity of these symptoms increased since that former episode?

    a. FREQUENCY? YES NO B. SEVERITY? YES NO

PAST MEDICAL HISTORY

Accidents or injuries?	YES	NO	_____		
Surgeries?	YES	NO	_____		
Cancer?	YES	NO	COPD	YES	NO
Arthritis	YES	NO	Neurologic Disorders	YES	NO
Pregnancy?	YES	NO	Parkinson's	YES	NO
Immunosuppression?	YES	NO	Pacemaker	YES	NO

Have you had other related P.T. or Body work? _____

By signing, I certify that all information in this form is true and correct to the best of my knowledge.

Patient (or Guardian) Signature: _____ Date: _____