Patient#_____ Provider_____

PHYSICAL THERAPY INITIAL EVALUATION FORM

PATIENT INFORMATION

DATE_____

NAME_____ OCCUPATION_____
(LAST) (FIRST)

BIRTHDATE_____ AGE_____ HEIGHT_____ WEIGHT_____lbs

HOME/CELL PHONE_____ EMPLOYER_____

CURRENTLY EMPLOYED? O YES O NO O MODIFIED

ADDRESS:_____ EMAIL:_____

REHAB INFORMATION

1. CHIEF COMPLAINT/AILMENT/INJURY_____

2. DATE OF INJURY_____ DATE OF SURGERY_____

3. BRIEFLY DESCRIBE HOW YOU WERE INJURED

_____

_____

4. HAVE YOU RECEIVED THERAPY FOR THIS CONDITION? O YES O NO WHEN?_____
HOW MANY VISITS?_____

5. HAS YOUR CONDITION BEEN GETTING: O WORSE O SAME O BETTER

6. ARE YOUR SYMPTOMS: O CONSTANT OR O INTERMITTENT

7. MARK THE NUMBER THAT BEST CORRESPONDS TO YOUR PAIN:

AT BEST: O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10 (EXCRUCIATING PAIN)

AT WORST: O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10 (EXCRUCIATING PAIN)

8. WHAT DECREASES/MAKES YOUR CONDITION BETTER? (MARK ALL THAT APPLY)

☐ BENDING ☐ MOVEMENT ☐ REST ☐ BETTER IN AM
☐ SITTING ☐ STANDING ☐ HEAT ☐ BETTER AS DAY PROGRESSES
☐ RISING ☐ WALKING ☐ ICE ☐ BETTER IN PM
☐ CHANGING POSITIONS ☐ LAYING ☐ MEDICATION ☐ N/A CAST JUST REMOVED

9. WHAT INCREASES/MAKES YOUR CONDITION WORSE? (MARK ALL THAT APPLY)

☐ BENDING ☐ MOVEMENT ☐ REST ☐ SNEEZE
☐ SITTING ☐ STANDING ☐ STAIRS ☐ DEEP BREATH
☐ RISING ☐ WALKING ☐ COUGH ☐ MEDICATION
☐ PROLONGED POSITIONING ☐ LAYING ☐ WORSE IN AM ☐ WORSE IN PM
☐ WORSE AS DAY PROGRESSES ☐ N/A CAST JUST REMOVED

10. PREVIOUS MEDICAL INTERVENTION (MARK ALL THAT APPLY)

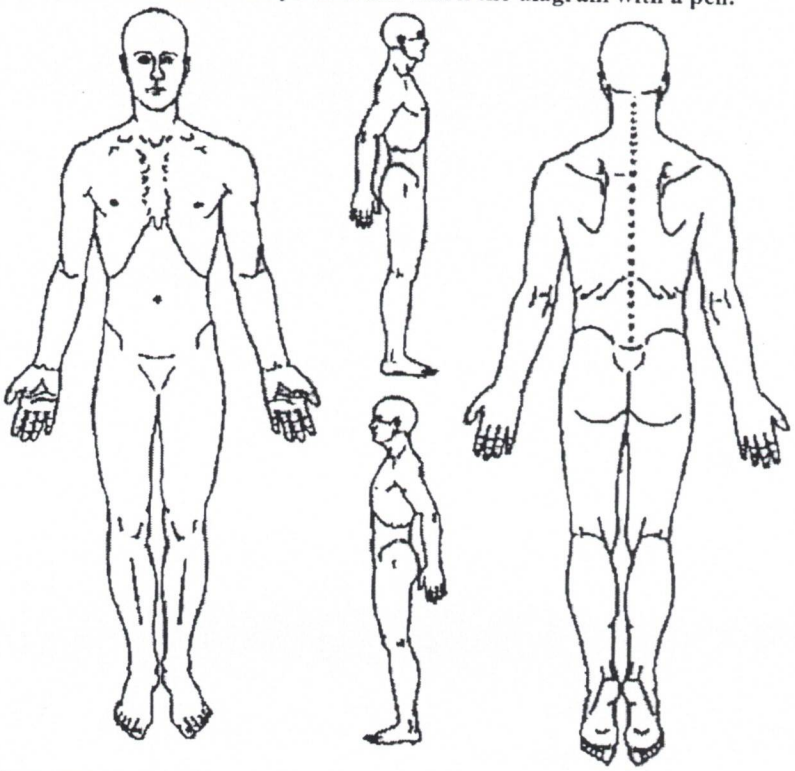
☐ X-RAY MRI ☐ CATSCAN ☐ INJECTIONS OTHER_____

11. WHAT ARE YOUR GOALS TO BE ACHIEVED BY THE END OF THERAPY? Patient#_____ Provider_____

_____

_____

DRAW IN AREAS OF PAIN ON BODY DIAGRAMS USING APPROPRIATE SYMBOLS. If you are completing this form on the computer, print form after completion and mark the diagram with a pen.



SEVERE PAIN	*******
MODERATE PAIN	00000000
DULL ACHE	∩∩∩∩∩∩
RADIATING PAIN	↑↓↑↓↑↓↑↓
NUMBNESS/TINGLING	XXXXXX

MEDICAL INFORMATION (MARK ALL THAT APPLY) **THIS INFORMATION IS CONFIDENTIAL AND REMAINS PART OF YOUR CHART

- ☐ DIFFICULTY SWALLOWING
- ☐ ARTHRITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART TROUBLE
- ☐ PACEMAKER
- ☐ EPILEPSY/SEIZURES
- ☐ HISTORY OF DRUG ABUSE
- ☐ MYOFASCIAL PAIN
- ☐ CANCER
- ☐ MOTION SICKNESS
- ☐ FEVER/CHILLS/SWEATS
- ☐ UNEXPLAINED WEIGHT LOSS
- ☐ BLOOD CLOTS
- ☐ SHORTNESS OF BREATH
- ☐ HISTORY OF SMOKING
- ☐ DIABETES
- ☐ FIBROMYALGIA
- ☐ STROKE
- ☐ OSTEOPOROSIS
- ☐ ANEMIA
- ☐ BLEEDING PROBLEMS
- ☐ HIV/HEPATITIS
- ☐ HISTORY OF ALCOHOL ABUSE
- ☐ DEPRESSION/ANXIETY
- ☐ PREGNANCY

PREVIOUS SURGERIES:_____

OTHER:_____

MEDICATIONS:

_____

_____

ALLERGIES:_____

PAYMENT SCHEDULE

Chiropractic/Acupuncture

Initial Visit (Standard) $85

Standard Visit $57

Standard Visit with Medical Acupuncture $57

Laser Therapy $62

Physiotherapy

Initial Visit $110

Follow Up Visit $90

Psychotherapy Each Visit $150

**** I understand payment is due on the same day that I have been treated.**

Patient Signature _____ Date _____

Informed Consent to Chiropractic/ Physiotherapy Treatment

There are risks and possible risks with manual therapy techniques used by doctors of chiropractic. In particular you should note:

A. While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures.

B. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in early stage of a stroke. In essence, there is a stroke in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

C. There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments of other chiropractic treatment.

D. There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic/physiotherapist.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss with my chiropractor/physiotherapist the nature and purpose of chiropractic/physiotherapy treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this consent.

I consent to the chiropractic/physiotherapy treatment recommended to me by my chiropractor/physiotherapist including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic/physiotherapy care.

Dated this _____ day of _____, 20_____

_____
Patient Signature (Legal Guardian)

_____
Witness of Signature

Name: _____

Name: _____