Body Forte Physical Therapy Evaluation

Date:_____

CONSENT: I understand that my diagnosis and treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered.

_____ (Sign)

Do you have any barriers to learning? Yes/No

If "Yes" please list _____

Last Name: _____First Name: _____

Address: _____

Birth date: _____(**mm/dd/yyyy**) Age: _____ Sex: M/F Smoker: Yes/ No Pregnant: Yes/No

Do you exercise at least 3 days per week? Yes/No

How did you hear about us?_____

Past Surgical History _____

_____

Current Medications _____

Employment Information

Occupation: _____

Employer: _____

TRN #: _____

Contact Information

Work Phone: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Emergency Contact

Name: _____Relationship: _____

Phone: _____ Alternate Phone: _____

Email Address:_____

Past Medical History: Please circle each condition that you have been told you have (or had)

Cancer	Diabetes	Kidney Disease
High Blood Pressure	Heart Disease	Angina/Chest Pain
Osteoporosis	Osteoarthritis	Rheumatoid Arthritis
Allergies/Asthma	Lung Disease	Have you had a recent illness (explain, if yes?)

_____

Do you take blood thinners? Yes/No Are you allergic to latex? (Explain, if yes)?

_____

Other:

Currently, I am experiencing (circle all that apply):

Fever/chills/sweats	Poor balance (falls)	Unexplained weight
Changes in appetite	Difficulty swallowing	Shortness of breath
Headaches	Changes in bowel or bladder function	Nausea/vomiting
Increased pain at night	Dizziness	Depression

How are you able to sleep at night? □ Fine □ Moderate Difficulty □ Only with medication

During the past month have you often been bothered by feeling down, depressed, or hopeless? Yes/No

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes/No

What date (approximately) did your present pain start?

_____

How (gradually, suddenly, injury)?

_____

My symptoms are currently (circle one): Getting better / About the same / Getting worse

What treatments have you received for this problem so far?

_____

What makes your symptoms better?

_____

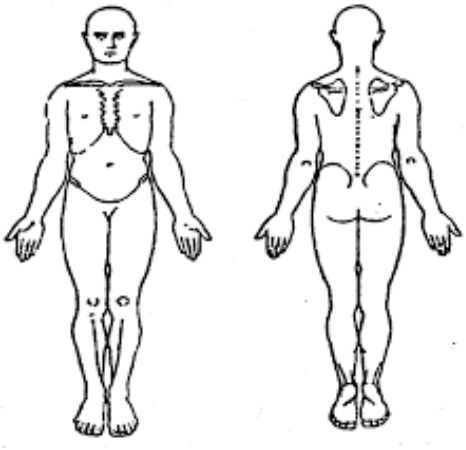
What makes your symptoms worse?

Have you had an X-ray, MRI, or other imaging study for this problem? Yes/No

Body Chart

Please mark the areas where you feel pain on the chart.

For the therapist
+/- Cough/Sneeze
+/- Saddle Anesth.
+/- Numb/Ting.



On the scale below, please circle the number which best represents the average level of pain you have experienced over the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Please circle the number below which best represents your overall average level of function:

Cannot do anything 0 1 2 3 4 5 6 7 8 9 10 **Able to do everything**

What are your personal goals for therapy at this time? _____

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

1) _____

2) _____

3) _____

Below for the therapist:

Rating: _____

Rating: _____

Rating: _____

AVG: _____

bodyforté
Physiotherapy + Pilates

Therapist Use

Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 **Able to Perform activity at same level as before (injury/problem)**

Physical Therapist Notes