

INITIAL EVALUATION SUBJECTIVE REPORT

Date: _____

Patient Name: _____ DOB: _____

THE FOLLOWING IS VERY IMPORTANT IN OUR EVALUATION PROCESS. PLEASE FILL OUT THESE FORMS AS SPECIFICALLY AS POSSIBLE TO PROVIDE US WITH A CLEAR PICTURE OF YOUR PRESENT PAIN, AND FUNCTION PROCESS.

1. Describe your symptoms: _____

❖ What is your primary complaint? _____

❖ Secondary Complaint? _____

2. Have you ever received treatment for this condition? Yes No

If yes please answer the following questions below:

What type of treatment? _____

How long was treatment? _____

Was the Treatment helpful? _____

3. Do you have any of the following medical condition?

Circulatory problem	Yes	No
High Blood Pressure	Yes	No
Heart Trouble	Yes	No
Pacemaker	Yes	No
Epilepsy	Yes	No
Diabetes	Yes	No
Pregnancy	Yes	No
Blackouts	Yes	No
Visual Problems	Yes	No
Weight Change (> 15 lbs)	Yes	No
Headaches	Yes	No
Ringin g in Ears	Yes	No
Bowel or Bladder Problems	Yes	No
Malignancy/Cancer	Yes	No
Stroke	Yes	No
Allergies	Yes	No

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4. List past medical history and dates of occurrences. (Include surgeries, accidents and other trauma)

Occurrence	Date
_____	_____
_____	_____
_____	_____
_____	_____

5. Approximately when did your symptoms begin?

6. How did your symptom(s) begin? (describe in details below)

7. Rate your pain from 0-10. (0=no pain and 10=unbearable pain)

- Intensity 0 1 2 3 4 5 6 7 8 9 10
- Frequency 0 1 2 3 4 5 6 7 8 9 10
- At its worst 0 1 2 3 4 5 6 7 8 9 10
- Most of the time 0 1 2 3 4 5 6 7 8 9 10
- At its best 0 1 2 3 4 5 6 7 8 9 10
- Night(Sleeping) 0 1 2 3 4 5 6 7 8 9 10

8. At what time of day are your symptoms the worst? _____

9. At what time of day are your symptoms the best? _____

10. Sleep evaluation

- Do you have trouble falling asleep? **Yes** **No**
- How many hours do you sleep? _____
- How many times do you wake up during the night? _____
- How long before you fall back to sleep? _____

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11. What activities increase your pain? _____

12. What activities decrease your pain? _____

13. Daily activities: Estimate the average time spent per day in each of the following activities.

Sleeping _____

Chores/Home care _____

Playing (specify sport or hobby) _____

Working _____

14. List all of the task/activities that you have difficulty performing and your tolerances (minutes/hours) for each task/activities. If you are no longer able to perform an activity, your tolerance would be "0".

Task	Tolerance
_____	_____
_____	_____
_____	_____
_____	_____

15. Rate your daily functional ability on a scale of 0-100%

On a good day _____%

On a bad day _____%

List what you would like to be able to do as a result of physical therapy below:

Activity	How often	By when
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____