ASSOCIATES IN PHYSICAL THERAPY
AIPT EAST WENATCHEE, WA

Today's Date:_____

Name:_____ DOB:_____

Physical Therapy - Initial Evaluation Form

1. Main Complaint (Reason for your visit today): _____

2. When did it start?:_____Is it: __Improving __Getting Worse __Staying same

3. How did it begin?:

___Motor Vehicle Accident ___Work Related Injury ___ Sports/Exercise Injury

___Post-surgery ___ Unknown Cause ___ Chronic Condition/Illness

___ Other (Please explain):_____

4. What **increases** your symptoms?:

__Sitting __Standing __Walking __ Lying Down __Lifting __Bending __Squatting

__Reaching overhead __Coughing/Sneezing __Stress/Anxiety __Running/Jumping

__Other:_____

5. What **decreases** your symptoms?:

__Sitting __Standing __Walking __ Lying Down __Massage __Heat __Ice __Medication

__Other:_____

6. Is your sleep disturbed due to pain? Yes or No

(if yes please explain)_____

7. Have you had any recent tests or imaging (past 3 months)?

__ X-ray __MRI __CT Scan __EMG __Bone Scan __Blood Tests __Ultrasound

__Other:_____

8. Have you had any treatment for this problem? (if yes please list):

_____

9. Do you have a pacemaker or any metal implants? Yes or No

10. Please list any surgeries (Including approx date):_____

_____

_____

11. Please list any **prescription medications** :_____

12. Have you been diagnosed with any of the following conditions (circle all that apply)?:

Arthritis	Balance Problems	Bowel/Bladder Problems	Heart Condition
Lung Condition	Cancer	Depression/Anxiety	Diabetes
Dizziness/Fainting	Eiplepsy/Seizures	High Blood Pressure	HIV/AIDS
Stroke	Vision Problems	Jaw Problems (TMJ)	Pregnancy (current)
Osteoporosis	Infection (current)	Other:_____	

Please turn the page over to complete

13. Use of Tobacco: __ Never/Infrequent __Previously but quit __Current pack/day:___

14. Use of Alcohol: __ Never __Rarely __ Moderate (2-4 drinks per week) __Daily

15. Use of Caffeine: __Coffee __Tea __Sodas (Drinks per day:_____)

16. Exercise: __Never __Rarely __Weekly __Daily (Type of exercise:_____)

17. Employment: ___Currently working normal duty ___Currently light duty ___Not currently working ____

Job Title:_____ Physical Demands: __Sedentary/Computer __Light __Medium__Heavy

18. Which activities are difficult for you because of your pain complaint (circle all that apply)?:

Sitting Standing Walking Reaching Lifting Pushing Pulling Carrying Sleeping

Other_____

Work Limitations/Restrictions:_____

19. Pain Assessment:

Circle the number that represents your level of pain at **best and at **worst** in the last few days:

Pain at **Worst**:											
(No Pain) 0	1	2	3	4	5	6	7	8	9	10	(Requiring ER)
Pain at **Best**:											
(No Pain) 0	1	2	3	4	5	6	7	8	9	10	(Requiring ER)

Please Mark: X Pain, **0** Tingling, **--** Numbness

Vital Signs:	Height:	BP:
(Filled in by staff)	Weight:	HR:
		SpO_2

_____ _____

Patient Signature *(or legal guardian/caregiver)* Date Therapist Signature Date