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

**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 | ☐ LYING | ☐ 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 | ☐ LYING | ☐ 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________________________________

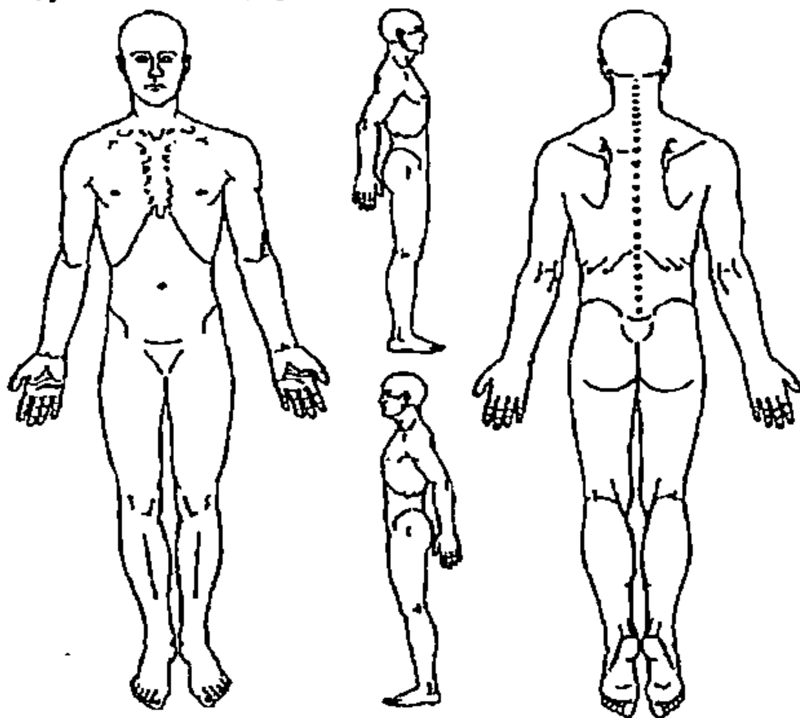
Patient#_______________ Provider_______

11. WHAT ARE YOUR GOALS TO BE ACHIEVED BY THE END OF THERAPY?

_______________________________________________

_______________________________________________

**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:_______________________________________________

QuickDASH - Initial Patient name:________________________ Date:__________

**INSTRUCTIONS**

This questionnaire asks about your symptoms as well as your ability to perform certain activities.
Please answer every question, based on your condition in the last week, by circling the appropriate number.
If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.
It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

**1. Please rate your pain level with activity:** NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

| | NO DIFFICULTY | MILD DIFFICULTY | MODERATE DIFFICULTY | SEVERE DIFFICULTY | UNABLE |
|---|---|---|---|---|---|
| 1. Open a tight or new jar | 1 | 2 | 3 | 4 | 5 |
| 2. Do heavy household chores (e.g., wash walls, floors). | 1 | 2 | 3 | 4 | 5 |
| 3. Carry a shopping bag or briefcase. | 1 | 2 | 3 | 4 | 5 |
| 4. Wash your back | 1 | 2 | 3 | 4 | 5 |
| 5. Use a knife to cut food. | 1 | 2 | 3 | 4 | 5 |
| 6. Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g., golf, hammering, tennis, etc.). | 1 | 2 | 3 | 4 | 5 |
| | NOT AT ALL | SLIGHTLY | MODERATELY | QUITE A BIT | EXTREMELY |
| 7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups? | 1 | 2 | 3 | 4 | 5 |
| | NOT LIMITED AT ALL | SLIGHTLY LIMITED | MODERATELY LIMITED | VERY LIMITED | UNABLE |
| 8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? | 1 | 2 | 3 | 4 | 5 |
| Please rate the severity of the following symptoms in the last week. (circle number) | NONE | MILD | MODERATE | SEVERE | EXTREME |
| 9. Arm, shoulder or hand pain. | 1 | 2 | 3 | 4 | 5 |
| 10. Tingling (pins and needles) in your arm, shoulder or hand. | 1 | 2 | 3 | 4 | 5 |
| | NONE | MILD | MODERATE | SEVERE DIFFICULTY | SO MUCH DIFFFICULTY THAT I CAN'T SLEEP |
| 11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number) | 1 | 2 | 3 | 4 | 5 |

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**Therapist Use Only**

Comorbidities:

- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: __________