SOZO PHYSICAL THERAPY

Initial Self-Evaluation Form

Name: _____ Date: ___/___/___ Date of Discomfort/Surgery: ___/___/___

Area of discomfort: _____ Referring Physician: _____

How did you hurt yourself? _____

_____

Primary Concerns/Complaints of Pain: _____

_____

What are things you are unable to do now? _____

_____

Pain Rating: _____ At Worst _____ At Best _____ Currently (0- No Pain, 10-Extreme Hospital Pain)

Pain Description (Circle all that apply) Dull/Achy Burning Throbbing Sharp Shooting Numbness

Other Pain Description: _____

What makes your pain worse: _____

What makes your pain better: _____

Do you have, or have you had any of the following?

Y/N	Diabetes	Y/N	Chest Pains/Angina	Y/N	High Blood Pressure
Y/N	Heart Attack	Y/N	Heart Palpitations	Y/N	Pacemaker
Y/N	Headaches	Y/N	Kidney Problems	Y/N	Cancer
Y/N	Endocrine Issues	Y/N	Stroke	Y/N	Bowel/Bladder Issues
Y/N	Urine Leakage	Y/N	Asthma	Y/N	Liver/Gallbladder
Y/N	Hypoglycemia	Y/N	Osteoarthritis	Y/N	Osteoporosis
Y/N	Hernia	Y/N	Seizures	Y/N	Metal Implants
Y/N	Dizziness/Fainting	Y/N	Fractures	Y/N	Surgeries
Y/N	Skin Abnormalities	Y/N	Nausea/Vomiting	Y/N	Ringing of Ears
Y/N	Rheumatoid Arthritis	Y/N	Smoking	Y/N	Other

Diagnostic Tests/Images: _____

Surgical History: _____

_____

Current Vitamins/Medications: _____

Patient Goals: _____

Are you currently under the care of a physician, psychiatrist or other health care professional other than the one who prescribed your physical therapy? O Yes O No

If Yes, Name/Specialty:_____

Have you ever had physical therapy or body work prior to this occasion? O Yes O No

If yes, what, when and how much:_____

Patient Signature: _____ Therapist Signature: _____