





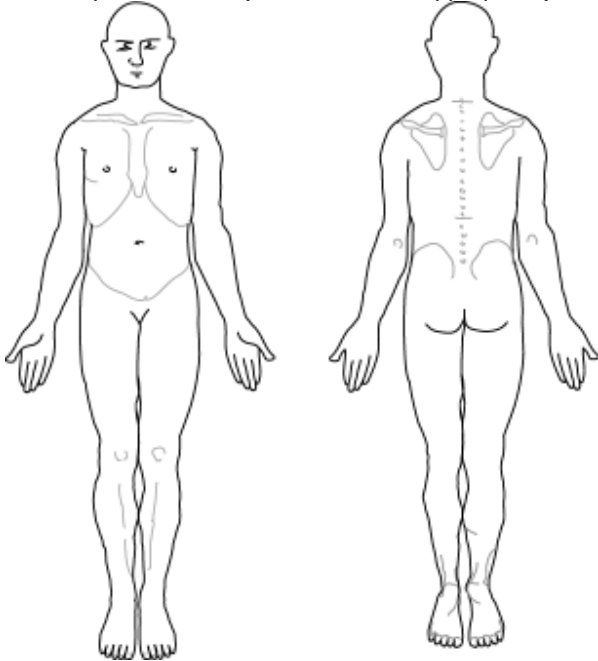
**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

*To insure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.*

**HISTORY OF PRESENT CONDITION**

1. What are your symptoms? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Localize areas of **pain** or **abnormal** sensation on the body chart below (Shade in where appropriate)



2. When did your symptoms begin?  
(Please indicate a specific date if possible) \_\_\_\_\_

3. Was the **onset** of this episode gradual or sudden?(Check one)  
 (1) gradual  (2) sudden

4. Which of the following **best describes** how your injury occurred? (if your condition is post-surgical please indicate as per original injury)

<input type="checkbox"/> (1) lifting	<input type="checkbox"/> (9) a blow to the face
<input type="checkbox"/> (2) a MVA (car accident)	<input type="checkbox"/> (10) being hit by a ball
<input type="checkbox"/> (3) a fall	<input type="checkbox"/> (11) a dental appointment
<input type="checkbox"/> (4) overuse (cumulative trauma)	<input type="checkbox"/> (12) throwing
<input type="checkbox"/> (5) trauma	<input type="checkbox"/> (13) an incident at work
<input type="checkbox"/> (6) degenerative process	<input type="checkbox"/> (14) unknown
<input type="checkbox"/> (7) during recreation/sports	<input type="checkbox"/> (15) other _____
<input type="checkbox"/> (8) running	

5. Since onset, are your symptoms getting: (Check one)  
 (1) better  (2) worse  (3) not changing

6. Have you had similar symptoms in the past? (1)  Yes (2)  No  
More than one episode? (1)  Yes (2)  No

7. Nature of pain/symptoms (check all that apply)

<input type="checkbox"/> (1) sharp	<input type="checkbox"/> (4) aching	<input type="checkbox"/> (7) constant
<input type="checkbox"/> (2) dull	<input type="checkbox"/> (5) periodic	<input type="checkbox"/> (8) other _____
<input type="checkbox"/> (3) throbbing	<input type="checkbox"/> (6) occasional	

8. As the day progresses, do your symptoms: (Check one)  
 (1) increase  (2) decrease  (3) stay the same

9. Does the pain wake you at night?  (1) No  (2) Yes  
if "yes", is it present  (1) while lying still  
 (2) only when changing positions  
 (3) both

10. Do you have pain/stiffness upon getting out of bed in the morning?  (1) Yes  (2) No

11. In what position do you sleep? (Check all that apply)

<input type="checkbox"/> (1) right side	<input type="checkbox"/> (4) back	<input type="checkbox"/> (6) back, sides, stomach
<input type="checkbox"/> (2) left side	<input type="checkbox"/> (5) chair/recliner	<input type="checkbox"/> (7) other _____
<input type="checkbox"/> (3) stomach		

12. Since the onset of your current symptoms have you had:

- (1) any difficulty with control of bowel or bladder function
- (2) fever/Chills
- (3) any numbness in the genital or anal area
- (4) numbness
- (5) any dizziness or fainting attacks
- (6) weakness
- (7) unexplained weight change
- (8) night pain/sweats
- (9) malaise (vague feeling of bodily discomfort)
- (10) problems with vision/hearing
- (11) none of the above

13. What aggravates your symptoms? (Check all that apply)

<input type="checkbox"/> (1) sitting	<input type="checkbox"/> (9) repetitive activities
<input type="checkbox"/> (2) going to/rising from sitting	including _____
<input type="checkbox"/> (3) lying down	<input type="checkbox"/> (10) household activities
<input type="checkbox"/> (4) walking	including _____
<input type="checkbox"/> (5) up/down stairs	<input type="checkbox"/> (11) standing
<input type="checkbox"/> (6) reaching overhead	<input type="checkbox"/> (12) squatting
<input type="checkbox"/> (6) reaching in front of body	<input type="checkbox"/> (13) sleeping
<input type="checkbox"/> (6) reaching behind back	<input type="checkbox"/> (14) coughing/sneezing
<input type="checkbox"/> (6) reaching across body	<input type="checkbox"/> (15) taking a deep breath
<input type="checkbox"/> (7) talking, chewing, yawning, all ( <i>circle one</i> )	<input type="checkbox"/> (16) looking up overhead
<input type="checkbox"/> (8) recreation/sports including _____	<input type="checkbox"/> (17) swallowing
	<input type="checkbox"/> (18) stress
	<input type="checkbox"/> (19) sustained bending
	<input type="checkbox"/> (20) other _____

14. What relieves your symptoms? (Check all that apply)

<input type="checkbox"/> (1) sitting	<input type="checkbox"/> (6) rest	<input type="checkbox"/> (11) massage
<input type="checkbox"/> (2) heat	<input type="checkbox"/> (7) standing	<input type="checkbox"/> (12) medication
<input type="checkbox"/> (3) cold	<input type="checkbox"/> (8) walking	<input type="checkbox"/> (13) nothing
<input type="checkbox"/> (4) stretching	<input type="checkbox"/> (9) exercise	<input type="checkbox"/> (14) other _____
<input type="checkbox"/> (5) wearing a splint/orthosis	<input type="checkbox"/> (10) lying down	

15. Have you had any previous treatment for this condition?  
(Check all that apply)

- (1) none
- (2) medication (oral)
- (3) joint manipulation
- (4) exercise
- (5) massage therapy
- (6) traction
- (7) bracing/taping
- (8) injection into the spine
- (9) injection into the skin/muscles
- (10) physical therapy
- (11) hypnosis
- (12) biofeedback
- (13) TENS unit
- (14) acupuncture
- (15) bed rest
- (16) overnight hospitalization
- (17) casting
- (18) other \_\_\_\_\_

16. Have you had any of the following tests?

- (1) none
  - (2) x-rays
  - (3) CT Scan
  - (4) MRI
  - (5) Arthrogram
  - (6) Stress X-ray Test (Telos)
  - (7) Bone Scan
  - (8) NCS
  - (9) Fluoroscope
  - (10) Vestibular
  - (11) other \_\_\_\_\_
- Test Results: \_\_\_\_\_

**MEDICATION**

Please list any prescription medications you are currently taking  
(*pain pills, injections and/or skin patches, etc.*):

Prescribing MD: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently taking any of the following over the counter medications?

- (1) aspirin
- (2) Tylenol
- (3) corticosteroids
- (4) antihistamines
- (5) vitamins/mineral supplements
- (6) Advil/Motrin/Ibuprofen
- (7) other \_\_\_\_\_

**PREVIOUS FUNCTIONAL LEVEL**

**Independent in all activities** (work, community, home, recreation)

**Self-care**

- Independent in all self-care activities (bathing, toileting, dressing, etc.)
- Difficulty performing self-care activities
- Need assistance with self-care activities
- Difficulty performing household chores

**Social**

- Need assistance with activities in community outside of home

**Hobbies:** \_\_\_\_\_

**WORK HISTORY**

**Occupation**

- (1) employed full time
- (2) employed part time
- (3) self employed
- (4) homemaker
- (5) student
- (6) retired
- (7) unemployed
- (8) other \_\_\_\_\_

**Physical activities at work** (check all that apply)

- (1) sitting
- (2) standing
- (3) phone use
- (4) repetitive lifting
- (5) heavy lifting
- (6) computer use
- (7) heavy equipment operation
- (8) driving
- (9) other \_\_\_\_\_

Are you currently receiving or seeking disability for this condition?  (1) Yes  (2) No

If not performing your normal activities at work do you plan to RETURN to your previous activity level?

- (1) Yes
- (2) No

**LIVING SITUATION**

- (1) live alone
- (2) live with family members/others
- (3) live with caregiver
- (4) home/apartment
- (5) retirement complex (SNF/ICF)
- (6) assisted living complex
- (7) other \_\_\_\_\_

**Setting**

- (1) stairs (railing)
- (2) stairs (no railing)
- (3) no stairs
- (4) ramp
- (5) elevator
- (6) uneven ground
- (7) other \_\_\_\_\_

**GENERAL HEALTH**

How would you rate your general health?

- Excellent
- Good
- Average
- Fair
- Poor

Do you exercise outside of normal daily activities?

- 5+ days/wk
  - 3-4 days/wk
  - 1-2 days/wk
  - occasionally
  - zero
- Exercise, Sports/Recreation consisting of \_\_\_\_\_

Do you drink caffeinated beverages?

- No
  - Yes
- How many/much per day \_\_\_\_\_

Do you smoke?

- No
  - Yes
- Packs of cigarettes per day \_\_\_\_\_

What is your stress level?

- Low
- Medium
- High

Are you seeing any health care providers other than the physical therapist for this current condition? (Please list) \_\_\_\_\_

**PAST MEDICAL HISTORY**

Have you ever had/been diagnosed with any of the following conditions? (Check all that apply)

- Cancer (type) \_\_\_\_\_
- Depression
- Stroke
- Kidney problems
- Thyroid problems
- Diabetes
- Multiple sclerosis
- Arthritis
- Head injury
- Stomach problems
- Parkinson's disease
- Infectious diseases (i.e. hepatitis, tuberculosis, etc.)
- Heart problems
- High blood pressure
- Lung problems
- Blood disorders
- Epilepsy/seizures
- Allergies
- Rheumatoid arthritis
- Osteoporosis
- Broken bone
- Circulation/vascular problems
- Other \_\_\_\_\_

Please list any recent/relevant past surgeries related to your current problem:

<b>SURGERY</b>	<b>DATE</b>
_____	_____
_____	_____

**FAMILY HISTORY**

Has anyone in your immediate family (parents, brothers, sisters) ever been treated of any of the following?

- Diabetes
- Heart disease
- High blood pressure
- Stroke
- Other \_\_\_\_\_
- Cancer
- Arthritis
- Osteoporosis
- Psychological condition

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
 TIME \_\_\_\_\_ AM/PM  Initial Visit  Discharge Visit

**PROBLEM AREA** (Please check one):

- Upper Extremity (A,D)  Lower Extremity (B,F)  Cervical/Thoracic (C,D)  Lumbar (D,F)  TMJ (C,E)

**FUNCTIONAL INDEX**

**PART I:** Answer all five sections in Part 1. Choose the one answer in each section that best describes your condition.

**WALKING**

- Symptoms do not prevent me walking any distance.
- Symptoms prevent me walking more than 1 mile.
- Symptoms prevent me walking more than 1/2 mile.
- Symptoms prevent me walking more than 1/4 mile.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

**WORK**

(Applies to work in home and outside)

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all (only light duty).
- I cannot do any work at all.

**PERSONAL CARE**

(Washing, Dressing, etc.)

- I can manage all personal care without symptoms.
- I can manage all personal care with some increased symptoms.
- Personal care requires slow, concise movements due to increased symptoms.
- I need help to manage some personal care.
- I need help to manage all personal care.
- I cannot manage any personal care.

**SLEEPING**

- I have no trouble sleeping.
- My sleep is mildly disturbed (less than 1 hr. sleepless).
- My sleep is mildly disturbed (1–2 hrs. sleepless).
- My sleep is moderately disturbed (2–3 hrs. sleepless).
- My sleep is greatly disturbed (3–5 hrs. sleepless).
- My sleep is completely disturbed (5–7 hrs. sleepless).

**RECREATION/SPORTS**

(Indicate Sport if Appropriate \_\_\_\_\_ )

- I am able to engage in all my recreational/sports activities without increased symptoms.
- I am able to engage in all my recreational/sports activities with some increased symptoms.
- I am able to engage in most, but not all of my usual recreational/sports activities because of increased symptoms.
- I am able to engage in a few of my usual recreational/sports activities because of my increased symptoms.
- I can hardly do any recreational/sports activities because of increased symptoms.
- I cannot do any recreational/sports activities at all.

**ACUITY** (Answer on initial visit.)

How many days ago did onset/injury occur? \_\_\_\_\_ days

**PART II:** Choose the one answer that best describes your condition in the sections designated by your therapist.

**A. UPPER EXTREMITY**

**CARRYING**

- I can carry heavy loads without increased symptoms.
- I can carry heavy loads with some increased symptoms.
- I cannot carry heavy loads overhead, but I can manage if they are positioned close to my trunk.
- I cannot carry heavy loads, but I can manage light to medium loads if they are positioned close to my trunk.
- I can carry very light weights with some increased symptoms.
- I cannot lift or carry anything at all.

**DRESSING**

- I can put on a shirt or blouse without symptoms.
- I can put on a shirt or blouse with some increased symptoms.
- It is painful to put on a shirt or blouse and I am slow and careful.
- I need some help but I manage most of my shirt or blouse dressing.
- I need help in most aspects of putting on my shirt or blouse.
- I cannot put on a shirt or blouse at all.

**REACHING**

- I can reach to a high shelf to place an empty cup without increased symptoms.
- I can reach to a high shelf to place an empty cup with some increased symptoms.
- I can reach to a high shelf to place an empty cup with a moderate increase in symptoms.
- I cannot reach to a high shelf to place an empty cup, but I can reach up to a lower shelf without increased symptoms.
- I cannot reach up to a lower shelf without increased symptoms, but I can reach counter height to place an empty cup.
- I cannot reach my hand above waist level without increased symptoms.

**B. LOWER EXTREMITY**

**STAIRS**

- I can walk stairs comfortably without a rail.
- I can walk stairs comfortably, but with a crutch, cane, or rail.
- I can walk more than 1 flight of stairs, but with increased symptoms.
- I can walk less than 1 flight of stairs.
- I can manage only a single step or curb.
- I am unable to manage even a step or curb.

**UNEVEN GROUND**

- I can walk normally on uneven ground without loss of balance or using a cane or crutches.
- I can walk on uneven ground, but with loss of balance or with the use of a cane or crutches.
- I have to walk very carefully on uneven ground without using a cane or crutches.
- I have to walk very carefully on uneven ground even when using a cane or crutches.
- I have to walk very carefully on uneven ground and require physical assistance to manage it.
- I am unable to walk on uneven ground.

## ■ C. CERVICAL/TMJ

### CONCENTRATION

- I can concentrate fully when I want to with no difficulty
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

### HEADACHES

- I have no headaches at all.
- I have slight headaches which come less than 3 per week.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come 4 or more per week.
- I have severe headaches which come frequently.
- I have headaches almost all of the time.

### READING

- I can read as much as I want without increased symptoms.
- I can read as much as I want with slight symptoms.
- I can read as much as I want with moderate symptoms.
- I cannot read as much as I want because of moderate symptoms.
- I can hardly read at all because of severe symptoms.
- I cannot read at all.

## ■ D. LUMBAR\*/CERVICAL/UPPER EXTREMITY

### DRIVING

- I can drive my car or travel without any extra symptoms.
- I can drive my car or travel as long as I want with slight symptoms.
- I can drive my car or travel as long as I want with moderate symptoms.
- I cannot drive my car or travel as long as I want because of moderate symptoms.
- I can hardly drive at all or travel because of severe symptoms.
- I cannot drive my car or travel at all.

### LIFTING

- I can lift heavy weights without extra symptoms.
- I can lift heavy weights but it gives extra symptoms.
- My symptoms prevent me from lifting heavy weights but I manage if they are conveniently positioned. (e.g. on a table)
- My symptoms prevent me from lifting heavy weights but I manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

## PAIN INDEX

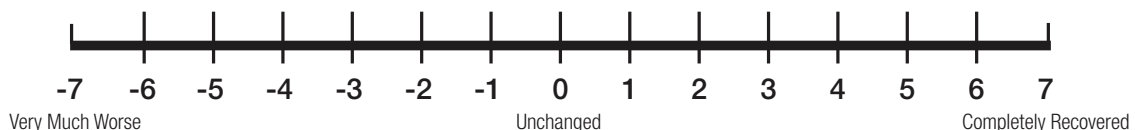
Please indicate the worst your pain has been in the last 24 hours on the scale below

No Pain  Worst Pain Imaginable

PLEASE DO NOT COMPLETE THE FOLLOWING SECTIONS ON FIRST VISIT

### GLOBAL RATING OF CHANGE

With respect to the reason you sought treatment, how would you describe yourself now compared to your first treatment at our clinic?  
(Circle one)



### ■ WORK STATUS (check most appropriate)

1.  No lost work time
2.  Return to work without restriction
3.  Return to work with modification
4.  Have not returned to work
5.  Not employed outside the home

Work days lost due to condition: \_\_\_\_\_ days

I am aware that the information gathered on this form may be used anonymously for research or publication. Please initial: \_\_\_\_\_

## ■ E. TMJ

### TALKING

- I can talk without any increased symptoms.
- I can talk as long as I want with slight symptoms in my jaws.
- I can talk as long as I want with moderate symptoms in my jaws.
- I cannot talk as long as I want because of moderate symptoms in my jaws.
- I can hardly talk at all because of severe symptoms in my jaws.
- I cannot talk at all.

### EATING

- I can eat whatever I want without symptoms.
- I can eat whatever I want but it gives extra symptoms.
- Symptoms prevent me from eating regular food, but I can manage if I avoid hard foods.
- Symptoms prevent me from chewing anything other than soft foods.
- I can chew soft foods occasionally, but primarily adhere to a liquid diet.
- I cannot chew at all and maintain a liquid diet.

## ■ F. LUMBAR\*/LOWER EXTREMITY

### STANDING

- I can stand as long as I want without increased symptoms.
- I can stand as long as I want, but it gives me extra symptoms.
- Symptoms prevent me from standing for more than 1 hour.
- Symptoms prevent me from standing for more than 30 minutes.
- Symptoms prevent me from standing for more than 10 minutes.
- Symptoms prevent me from standing at all.

### SQUATTING

- I can squat fully without the use of my arms for support.
- I can squat fully, but with symptoms or using my arms for support.
- I can squat 3/4 of my normal depth, but less than fully.
- I can squat 1/2 of my normal depth, but less than 3/4.
- I can squat 1/4 of my normal depth, but less than 1/2.
- I am unable to squat any distance due to symptoms.

### SITTING

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- My symptoms prevent me sitting more than 1 hour.
- My symptoms prevent me sitting more than 1/2 hour.
- My symptoms prevent me sitting more than 10 minutes.
- My symptoms prevent me from sitting at all.

\* Lumbar questions adapted from Oswestry.