

# Hereford Physical Therapy and Sports Medicine

## Initial Evaluation History Sheet

Name :	Date:	Age:
Physician:	Diagnosis:	
Occupation/ Activity:		

LEFT

RIGHT

Date of injury or surgery

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How did you injure yourself? (Circle)

Fall	Overuse	At Work	Sports	Unknown
Explain				

Have you had this injury before? (Circle)	Y	N
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Have you had physical therapy before? (Circle)	Y	N
If yes when		

Any other medical history (Circle)

Diabetes	High Blood Pressure	Heart Condition
Cancer	Arthritis	Osteoporosis
Surgeries	Other	

Are you taking any medications? (Circle)	Y	N
Please list them :		

Do you have any allergies ?	Y	N
Please list :		

Presently, what is your chief complaint?

Do you have pain?	Y	N
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Where is your pain?

(Circle) for the following

Your Pain Level                      None    1 2 3 4 5    6 7 8 9 10    worst

Pain Frequency	Intermittent	Constant
Type of Pain	Sharp	Dull                      Burning

Do you have stiffness?	Y	N
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Do you have swelling?	Y	N
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Are you able to work right now?	Y	N
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Are you able to enjoy your hobbies or sports?	Y	N
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Over Please

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Please circle all activities that are difficult at this time:

Dressing	Brushing Teeth	Sleeping through the night
Washing your hair	Eating	Sitting (long periods)
Typing	Going up/down stairs	Driving
Lifting	Walking	Standing (long periods)
Throwing	Kneeling	Bending
Other:	Other:	Other:

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Right now, I feel I am getting (circle)

Better

Worse

Staying the same

(For therapist use only)


Patient Signature:

Date: