

**INITIAL SELF EVALUATION FORM**

Name \_\_\_\_\_

Date \_\_\_\_\_

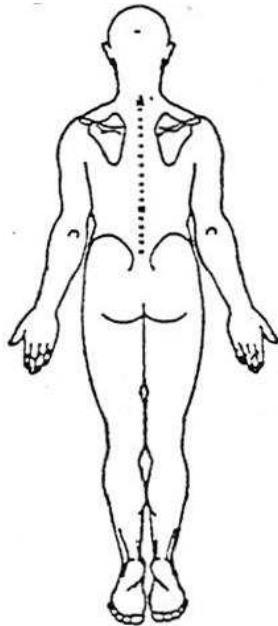
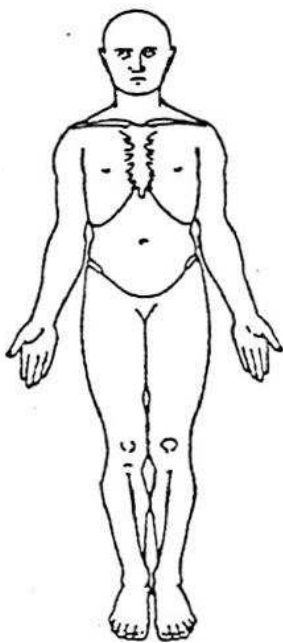
Please tell us about yourself, so that we can serve you better. If you have difficulty answering any question, or if it doesn't apply to you, just leave it blank. You will have ample opportunity to clarify or explain any of your answers during your evaluation and treatment sessions.

Who referred you to us? \_\_\_\_\_

What is your reason for seeking therapy? \_\_\_\_\_

Please mark or shade in any areas where you have been experiencing discomfort. You can label each area with one or more descriptor from the following list:

- |                   |          |   |          |
|-------------------|----------|---|----------|
| Severe            | Sharp    | Burning                                   | Aching   |
| Moderate          | Dull     | Throbbing                                 | Stabbing |
| Numbness/tingling | Weakness | Radiating (indicate direction with arrow) |          |



List & rate each symptom you have been experiencing. Rate on a scale of 0-10, 0 is no pain-10 the worst pain you can imagine.

- a. \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10
- b. \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10
- c. \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10
- d. \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

When did your symptoms begin? \_\_\_\_\_

What do you think causes your symptoms? \_\_\_\_\_

What makes your symptoms worse? Sitting \_\_\_ Standing \_\_\_ Bending \_\_\_ Lifting \_\_\_ Walking \_\_\_ Running \_\_\_

Other, describe: \_\_\_\_\_

What eases your symptoms? \_\_\_\_\_

**Please describe the daily pattern of your symptoms. Type and severity of discomfort.**

First thing in the morning? \_\_\_\_\_

Later morning? \_\_\_\_\_

Late afternoon? \_\_\_\_\_

Evening? \_\_\_\_\_

Is your sleep pattern disturbed? \_\_\_\_\_

How many hours of sleep do you typically have per night? \_\_\_\_\_

Have you been seen by a physician for these symptoms? If so, what was the diagnosis? \_\_\_\_\_

Have you had any diagnostic tests done? (X-rays, MRI, EMG/NCV, etc.) If so what were the results? *(If you have access to any reports or films, it would be helpful to bring them in.)* \_\_\_\_\_

Have you had any previous treatment for this condition? (Previous Physical Therapy, chiropractic, massage, etc.)

What were the results? \_\_\_\_\_

Are you presently taking any medications? Please list. \_\_\_\_\_

What is your occupation? \_\_\_\_\_

How much, if any, is your work affected by your condition? \_\_\_\_\_

What recreational or leisure activities do you enjoy? \_\_\_\_\_

Describe your types and amounts of routine exercise? \_\_\_\_\_

Are these affected by your condition? \_\_\_\_\_

Please describe your goals for your treatment? \_\_\_\_\_

How much time (per day or per week) are you willing to commit to improve your symptoms?

Other Comments: