INITIAL EVALUATION SUBJECTIVE REPORT

Date: _____

Patient Name: _____ **DOB:** _____

THE FOLLOWING IS VERY IMPORTANT IN OUR EVALUATION PROCESS. PLEASE FILL OUT THESE FORMS AS SPECIFICALLY AS POSSIBLE TO PROVIDE US WITH A CLEAR PICTURE OF YOUR PRESENT PAIN, AND FUNCTION PROCESS.

1. **Describe your symptoms:** _____
_____
_____

   - **What is your primary complaint?** _____
_____
_____

   - **Secondary Complaint?** _____
_____
_____

2. **Have you ever received treatment for this condition? Yes No**
   If yes please answer the following questions below:
   What type of treatment? _____
   How long was treatment? _____
   Was the Treatment helpful? _____

3. **Do you have any of the following medical condition?**

Circulatory problem	**Yes**	**No**
High Blood Pressure	**Yes**	**No**
Heart Trouble	**Yes**	**No**
Pacemaker	**Yes**	**No**
Epilepsy	**Yes**	**No**
Diabetes	**Yes**	**No**
Pregnancy	**Yes**	**No**
Blackouts	**Yes**	**No**
Visual Problems	**Yes**	**No**
Weight Change (>15 lbs)	**Yes**	**No**
Headaches	**Yes**	**No**
Ringing in Ears	**Yes**	**No**
Bowel or Bladder Problems	**Yes**	**No**
Malignancy/Cancer	**Yes**	**No**
Stroke	**Yes**	**No**
Allergies	**Yes**	**No**

4. List past medical history and dates of occurrences. (Include surgeries, accidents and other trauma)

Occurrence	**Date**
_____	_____
_____	_____
_____	_____
_____	_____

5. Approximately when did your symptoms begin?
_____

6. How did your symptom(s) begin? (describe in details below)
_____
_____
_____
_____

7. Rate your pain from 0-10. (0=no pain and 10=unbearable pain)

Intensity 0 1 2 3 4 5 6 7 8 9 10

Frequency 0 1 2 3 4 5 6 7 8 9 10

At its worst 0 1 2 3 4 5 6 7 8 9 10

Most of the time 0 1 2 3 4 5 6 7 8 9 10

At its best 0 1 2 3 4 5 6 7 8 9 10

Night(Sleeping) 0 1 2 3 4 5 6 7 8 9 10

8. At what time of day are your symptoms the worst? _____

9. At what time of day are your symptoms the best? _____

10. Sleep evaluation
Do you have trouble falling asleep? **Yes** **No**
How many hours do you sleep? _____
How many times do you wake up during the night? _____
How long before you fall back to sleep? _____

11. What activities increase your pain? _____

_____

12. What activities decrease your pain? _____

13. Daily activities: Estimate the average time spent per day in each of the following activities.

Sleeping _____
Chores/Home care _____
Playing (specify sport or hobby) _____
Working _____

14. List all of the task/activities that you have difficulty performing and your tolerances (minutes/hours) for each task/activities. If you are no longer able to perform an activity, your tolerance would be "0".

Task	**Tolerance**
_____	_____
_____	_____
_____	_____
_____	_____

15. Rate your daily functional ability on a scale of 0-100%

On a good day _____%
On a bad day _____%

List what you would like to be able to do as a result of physical therapy below:

Activity	**How often**	**By when**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____