MFR YOGA

OUTPATIENT PHYSICAL THERAPY EVALUATION: **DATE:**

Name		**DOB**		**Age**		**Gender**	
Address		**Zip**		**City/ State**			
Phone		**Status**		**Occupation**			
Insurance		**SSN #**		**EMAIL**			
Auth/Claim#		**Private**		**WComp**		**MVA**	
Diagnosis				**Physician**			

SUBJECTIVE Complaints (reasons why you are seeking PT)

1.

2.

3.

Date of Injury (DOI)		**Prior level of Function before DOI:**	

List activities you are NOT able to or have DIFFICULTY doing as a result of your current pain:

1.

2.

3.

4.

Patient's Goals for seeking therapy:

Other Past Medical History:

Past Surgical History:

HOW WOULD YOU RATE YOUR PAIN?

No pain					moderate					extreme pain
0	1	2	3	4	5	6	7	8	9	10

Pain Description: Is it radiating? Where?

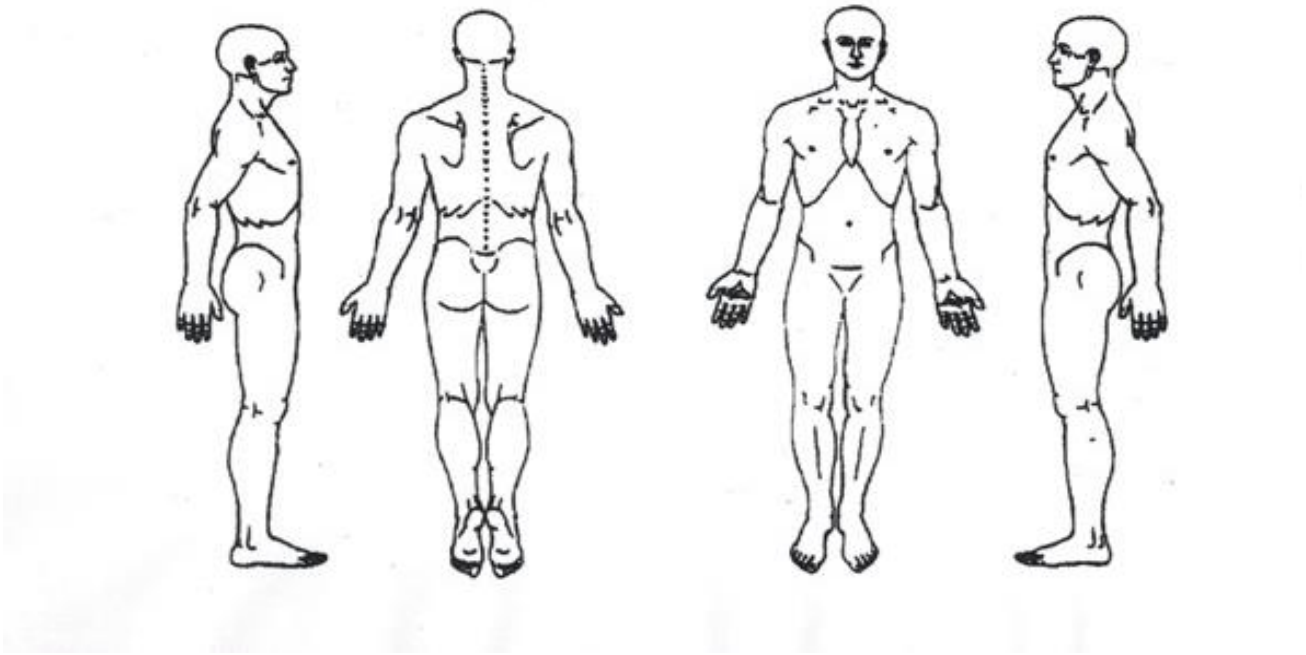
Is it constant? Is it on /off? Is it getting worse?

Any numbness or tingling?

What percentage of your daily tasks your pain affects your ability to move or do things?

Shade in all areas of pain. Grade the intensity of pain in each area using 0 - 10 scale:

0 = no pain / no discomfort, 10 = the worst pain you can imagine



List of prescription medications currently taking including herbal / vitamins:

Any Allergies?

Social Living Status: Do you live alone? **Who lives with you?**

Where do you work? **What do you do?**

Health habits / How do you take care of yourself ?

Do you smoke?

Prior treatment interventions performed/received in the past:

Any Malignancy, Medical Precautions or Limitations given by Physician:

Do you have a follow up appointment with your referring doctor?

I hereby acknowledge that all information provided are true and correct.

Patient Name: Date of Appointment: