



PHYSICAL THERAPY
PILATES STUDIO
81 CERNON ST. VACAVILLE, CA

Patient Subjective Evaluation: Please Print
This form must be completed as part of your physical therapy

Name: _____ Age: _____ Sex: M F Date of Birth: _____
Occupation: _____
Currently working: YES Full Time Part Time Light duty NO
Date of Injury or surgery: _____
Describe Injury or surgery: _____

Is this a work related injury?: Yes No Is this injury related to a motor vehicle accident?: Yes No

Check recent diagnostic tests and give date of tests:
 Xray _____ CT Scan _____ MRI _____ None _____ Other _____
Have you received Physical Therapy services in the **past month** in the following settings:
 Hospital or Extended Care facility Home Health Outpatient Physical Therapy No
Are you receiving other treatments for this problem? YES NO
 Chiropractic Pain Management Other _____

List medications taken regularly. List Name of drug, dose, reason for drug and how frequently you take the drug:

Are you currently experiencing or have you experienced any of the following symptoms **in the past 3 months**?

Balance/Falls Pins/Needles Numbness/Tingling Shortness of Breath
 Bowel/Bladder problems Vision problems Dizziness Night sweats NONE

Check the diagnoses or conditions you have experienced.

Hypertension Epilepsy/seizures Diabetes Autoimmune Disease Neuromuscular disease
 Pacemaker Stroke Cancer Polio Other _____
 Heart disease Allergic reaction to _____ NONE

List all previous surgeries or hospitalizations and dates:

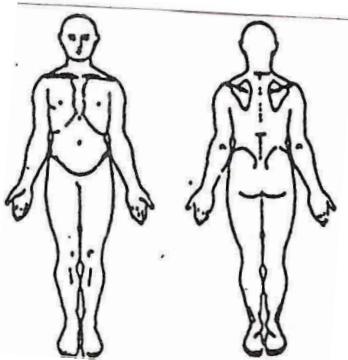
Are your current symptoms :

- Getting Better Slowly Improving Not Changing Getting Worse

Circle the **AVERAGE** intensity of your symptoms:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 SEVERE PAIN

Mark on the Drawing below your area of symptoms.



Which of the following **describe** your symptoms?:

- Sharp Shooting Dull ache Throbbing
 Burnin Numb Tingling Other _____

How **often** do you experience symptoms?

- Constantly (at rest and with activity — 76% to 100% of the day)
 Frequently (51% - 75% of the day)
 Ocassionally (26% - 50% of the day)
 Intermittently (0% - 25% of the day)

What **increases** your pain?

- Sitting Standing Lying in bed Lifting Overhead activities Bending
 Walking Stairs Driving Carrying Squatting Twisting
 Other _____

What **decreases** your pain?

- Sitting Standing Lying in bed Walking Stretching Exercise/Activity
 Heat Ice Medication Rest Other _____

What is your goal for Physical Therapy? _____

DATE

PATIENT SIGNATURE



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