LoHi PHYSICAL THERAPY
CATALYST THERAPIES LLC

303-458-9660 Phone 303-458-9661 Fax
info@LoHiPT.com www.LoHiPT.com

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.

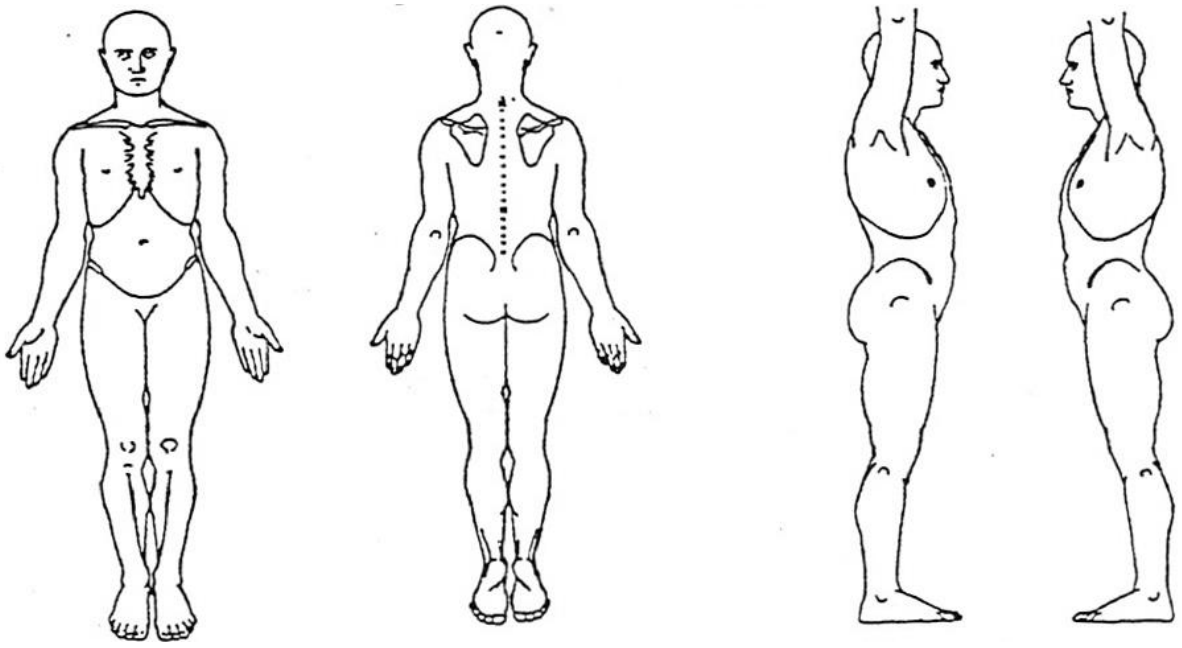
Who referred you to us? _____

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? _____

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

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:

_____