TRAINING SOLUTIONS

Individual Care. Integrative Solutions.

Client/Patient Evaluation Form

Name _____
Address _____
Email _____
Phone _____
Age _____
Height_____Weight_____
Gender ❑ M ❑ F
Occupation _____
Employer _____
Emergency Contact _____
Relationship _____
Emergency Contact's phone number _____

Name of Therapist evaluating Client/Patient _____
Date _____

Please explain the injury are you here to have treatment for today: _____
_____

What activity irritates it most? _____
_____

When did the injury occur?_____
_____

What were you doing? _____
_____

Has a doctor or health professional ever told you that you have or had any of the following conditions? Please check all that apply:

❑ Congenital heart defect
❑ Cancer
❑ Heart problems/heart disease
❑ Joint replacement/repair
❑ Joint, tendon or muscular pain
❑ Gastrointestinal issues
❑ Osteoporosis
❑ Skin problems
❑ Pacemaker
❑ Psychological
❑ High or low blood pressure
❑ High or low blood sugar
❑ Chest pain/angina/palpitations
❑ High cholesterol
❑ Abdominal pain/bloating/gas
❑ Emphysema
❑ Shortness of breath
❑ Poor balance or recent falls
❑ Coughing/wheezing on exertion
❑ Dizziness/vertigo/fainting/blackouts
❑ Gout
❑ Severe headaches
❑ Rheumatoid arthritis
❑ Prostate problems
❑ Anemia
❑ Epilepsy/Seizure disorders
❑ Ulcers
❑ Circulation problems or blood clots
❑ Depression
❑ Liver disease
❑ Kidney disease
❑ Sexually transmitted diseases or HIV/AIDS
❑ Tuberculosis
❑ Lung Disease
❑ Thyroid Problems
❑ Allergies
❑ Asthma/bronchitis/ pneumonia/chronic cough
❑ Diabetes
❑ Stroke
❑ Chemical dependency (i.e. alcoholism)
❑ Latex allergy
❑ Lyme disease
❑ Hepatitis A,B,C
❑ Painful bowels/ loose stool/constipation
❑ Multiple sclerosis
❑ Other _____
_____
_____

Provide details regarding conditions checked: _____
_____
_____
_____
_____

Are you under a doctor's care?
❑ Yes ❑ No

If yes, please explain and give doctor's name:
_____

Please list any other medical conditions you have: _____
_____
_____
_____

Have you recently noted:

❑ Weight loss/gain
❑ Nausea/vomiting
❑ Weakness
❑ Numbness/tingling
❑ Fatigue
❑ Dizziness
❑ Shortness of breath
❑ Headaches
❑ Fever/chills/sweats
❑ Pain at night
❑ Difficulty swallowing
❑ Change of appetite

Are you pregnant?
❑ Yes ❑ No

How much water do you drink a day? _____

How many cigarettes do you smoke a day? _____

How much coffee or caffeinated beverages do you drink a day? (ounces) _____

How many alcoholic beverages do you consume in one week? _____

Do you have any food cravings or intolerances? _____
_____

Describe your typical meals of breakfast, lunch, dinner and snacks including times:_____
_____
_____
_____

How is your energy? _____

What time of day is it
highest?_____ Lowest? _____

How do you feel emotionally? _____
_____

Do you have (check all that apply):
❑ Depression
❑ Anxiety
❑ Panic attacks
❑ Irritability or short temper
❑ Poor memory
❑ Difficult concentration
❑ Other _____

Relationship status:
❑ Married/stable relationship ❑ Single

How do you feel about your relationship? _____
_____
_____

How do you feel about your work? _____
_____
_____

How are your family relationships? _____
_____
_____

How / where do you hold stress? _____
_____
_____

How do you relax? _____
_____
_____

Describe your social outlets, leisure activities, and hobbies: _____
_____
_____

How many hours do you generally sleep per night? _____
Number of times you wake up_____
Do you have night sweats? _____
Do you have trouble:
❑ Falling asleep ❑ Staying asleep ❑ Disturbed sleep
Describe: _____
_____

What forms of exercise do you practice and how often? _____
_____
_____

Accidents, injuries, or major illnesses including motor vehicle (include date): _____
_____
_____

Surgeries (include date): _____
_____
_____

Medications, vitamins, herbs, teas, over-the-counter medications and supplements (include dosage):
_____
_____
_____

Family medical history: (Please list major illnesses in your close family such as diabetes, heart disease, high blood pressure, neurological disorders, psychological disorder, orthopedic disorders, etc.)
_____
_____
_____

What other practitioners are you currently seeing for this condition? (Please list all with the frequency, duration, and treatment involved) _____
_____
_____

Describe what condition you are here to be treated for and how long you have had it (date of onset):
_____
_____
_____

Have you had any prior episodes for this condition? How many? _____
_____
_____

Have you undergone any diagnostic testing:

❑ Nerve Conduction Velocity
❑ EMG
❑ Bone Scan
❑ MRI
❑ Cardiac Stress Test
❑ CT scan
❑ Blood Test
❑ Doppler Studies
❑ Urinalysis
❑ X-rays
❑ Other: _____
_____

Results from the above tests: _____
_____
_____

Was the onset due to:

❑ Injury at Home
❑ Slow onset
❑ Chronic
❑ Work related
❑ Repetitive motion
❑ Sports
❑ Recreational
❑ Trauma
❑ Unknown
❑ Other: _____

Was the onset due to:

❑ Backward bending
❑ Forward bending
❑ Twisting R or L
❑ Crushing
❑ Heavy lifting
❑ Illness
❑ Trauma
❑ Overuse
❑ Other: _____

What was the onset speed of your injury:

❑ Gradual ❑ Sudden

Which of the following describes your symptom trend:

❑ Improving ❑ Unchanging ❑ Worsening

For the following activities check the box that applies to your current symptoms:

ACTIVITY	Numbness	Pain	Stiffness
Arm/hand Activities	❑	❑	❑
Lying on Back	❑	❑	❑
Ascending Stairs	❑	❑	❑
Overhead Activity	❑	❑	❑
Ballistic Activities	❑	❑	❑
Pinching/Grasping	❑	❑	❑
Bending	❑	❑	❑
Quick Movements of Head/Neck	❑	❑	❑
Climbing Ladders	❑	❑	❑
Reaching	❑	❑	❑
Computer Use	❑	❑	❑
Sitting	❑	❑	❑
Crawling	❑	❑	❑
Squatting	❑	❑	❑
Crouching	❑	❑	❑
Standing	❑	❑	❑
Descending Stairs	❑	❑	❑
Walking	❑	❑	❑
Driving	❑	❑	❑
Walking on Uneven Ground	❑	❑	❑
Kneeling	❑	❑	❑
Work Activities	❑	❑	❑
Lying on L Side	❑	❑	❑
Lying on Stomach	❑	❑	❑
Lying on R Side	❑	❑	❑

What is the frequency of your pain?

❑ Constant
❑ Intermittent/daily
❑ Occasional (less than daily)
❑ Sporadic (less than weekly)
❑ More specifically _____

What is your pain intensity on average?
(0 = no pain, 10 = worst imaginable)
At its worst_____
At its best_____
At rest_____
At night_____
With movement (please specify movements) _____
_____

Please indicate where your pain or symptoms are by shading areas below:
What specific remedies or movements decrease your pain?_____
_____

Does it radiate and if so where? _____
_____

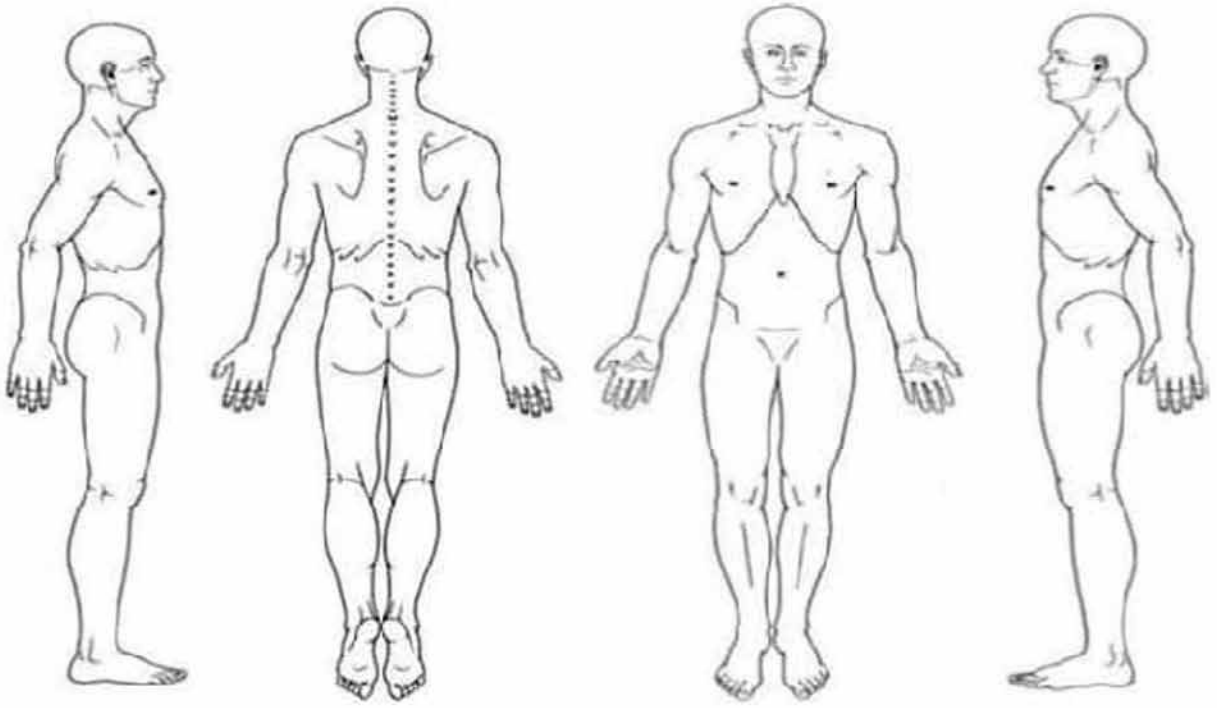
Does your pain change morning to noon to evening?
❑ Yes ❑ No
Describe: _____
_____

What is the quality of your pain?

❑ Sharp
❑ Dull
❑ Achy
❑ Burning
❑ Stabbing
❑ Throbbing
❑ Pulsating
❑ Deep
❑ Boring
❑ Shooting
❑ Searing
❑ Radiating
❑ Tearing
❑ Gripping
❑ Gnawing
❑ Ripping
❑ Other _____

Do you have:
❑ Pins and needles
❑ Numbness
❑ Tingling
❑ Loss of sensation
❑ Hypersensitivity
❑ Strength loss
If so, where?_____

Please indicate which activities you have difficulty or pain with:
❑ Cooking
❑ Dressing
❑ Driving
❑ House cleaning
❑ Toileting
❑ Other_____



Please indicate how long you can perform each activity before your pain gets worse:

Walking _____
Standing _____
Sitting _____
Kneeling _____
Running _____
Biking _____
Elliptical _____
Swimming _____
Rowing _____
Lifting (pound capacity)_____
Driving _____
Computer use_____

How many hours do you spend on the computer each day?_____

Have you ever received an ergonomic workspace evaluation?
❑ Yes ❑ No

What was your previous functional capacity and lifestyle before the injury or pain onset? _____
_____
_____

Are you seeking or planning to seek legal counsel for this condition?
❑ Yes ❑ No

If yes, please provide name of attorney and details: _____
_____
_____

I certify that the above information is correct to the best of my knowledge. I have disclosed all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.
I understand that these services are a health aid and not a substitute for a doctor's care.

Client Signature: _____

Date: _____

Evaluator Signature: _____

Date: _____