FREE FLOW PHYSICAL THERAPY, PLLC
Medical Information Form – Initial Evaluation

In order to thoroughly assess you, please take the time to fill out the questions below as accurately as you can. Thanks!

Personal Information									
Name					**Date**				
Gender	Male Female				**DOB**			**Age**	
Height		Weight		Are you Right- or Left-Handed?		Blood Pressure		Pulse	
Any customs or religious beliefs or wishes that might affect care?									

DESCRIBE YOUR CURRENT CONDITION AND CHIEF COMPLAINT			
The problem(s) for which you seek physical therapy			
Circle your worst pain level in the past couple of days	Mild Moderate Severe 0 1 2 3 4 5 6 7 8 9 10	When did the problem(s) begin? (date)	
What happened?			
What makes the problem(s) better?			
What makes the problem(s) worse?			

Describe any Past History with your Current Condition and Chief Complaint			
Have you ever had the problem(s) before?	Yes / No	If yes, what did you do for the problem(s)?	
If yes, did the problem(s) get better?	Yes / No	If yes, about how long did the problems last?	

Describe any Other Past History with Physical Therapy			
Have you had physical therapy before?	Yes / No	If yes, for how long, and for what reason?	
Are you under the care of a chiropractor / acupuncturist / osteopath?	Yes / No	If yes, for how long, and for what reason?	

Daily Life and your Goals for Physical Therapy						
Are any of your usual everyday activities affected?	Bed mobility	Transfers	Walking	Stairs	Self care	Household chores
	Work activities	If yes, describe how?				
What are your goals for physical therapy?						

General Health Status						
Good	Fair	Poor	Any comment?			
Aids and Protheses. Do you use a:	Cane, walker	Hearing aids	Dentures	Pacemaker	Glasses	Contact lenses
	Any prosthesis	In soles	Other			

DESCRIBE YOUR SOCIAL / HEALTH HABITS	
Diet	
Exercise (beyond normal daily activities and chores)	
Smoking	
Alcohol and other drugs	

Additional Medical Information	
When was your last physical check up with your doctor?	
Any past surgeries? If yes, when and for what reason?	
Any medical tests (MRI, Bone scan, etc.)? If yes, why?	
Any other medical conditions you have or had?	
Any medications you are on?	

OTHER RECOMMENDATIONS/REFERRALS