



# Irving Orthopedics & Sports Medicine

## INITIAL SELF-EVALUATION

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Last day worked (if applicable): \_\_\_\_\_

Have you had surgery for this condition?: YES / NO If yes, on what date? \_\_\_\_\_

*Please take a moment to fill out the following questions as accurately as able. This information will greatly improve my ability to help you with your condition. Please don't forget to sign at the end. If you need assistance with this form, please contact the front desk.*

### PRESENT CONDITION:

A. Please mark your primary complaint:

Loss of:  function  motion  strength

Pain with:  walking  sleeping  standing  sitting  sports  reaching  lifting  work duties

Other: \_\_\_\_\_

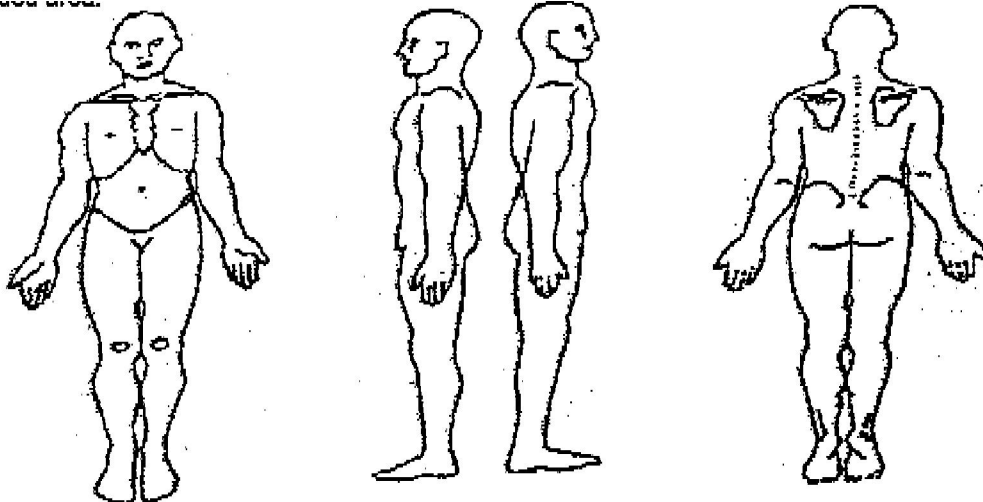
B. Please explain the condition that brought you to Physical / Occupational Therapy or why your doctor sent you here.

\_\_\_\_\_  
\_\_\_\_\_

On what date did this occur? If there was no injury, for how long have you had these symptoms?

\_\_\_\_\_  
\_\_\_\_\_

C. Please shade in area or areas where you are experiencing pain/symptoms. Then draw a line from the words below to the shaded area on body where you feel that symptom. Feel free to use more than one description for each shaded area.



- Sharp
- Dull
- Ache
- Stabbing
- Numbness/Tingle
- Burning
- Weakness
- Stiffness
- Radiating
- Burning
- Severe
- Moderate

D. Please list each symptom area above and rate it on the scale provided.  
( 0 = No pain, 5 = moderate pain, 10 = most severe pain (need to go the emergency room)

<u>SYMPTOMS</u>	<u>SEVERITY</u>
1. _____	0 1 2 3 4 5 6 7 8 9 10
2. _____	0 1 2 3 4 5 6 7 8 9 10
3. _____	0 1 2 3 4 5 6 7 8 9 10

E. Overall your symptoms are: ( )getting better ( )worsening ( )staying the same?

F. What makes your symptoms worse?

- ( ) Sitting how long? \_\_\_\_\_ ( ) Standing how long? \_\_\_\_\_  
( ) Bending (direction) \_\_\_\_\_ ( ) Walking how long? \_\_\_\_\_  
( ) Other – please specify \_\_\_\_\_ ( ) Reaching direction? \_\_\_\_\_

G. What eases your symptoms?

- ( ) Sitting ( ) Standing ( ) Ice ( ) Heat  
( ) Rest ( ) Elevation ( ) Other – please specify \_\_\_\_\_

H. Please circle how often you experience the symptoms: ( )constant ( )comes & goes ( )certain times of day

( )Certain positions Other \_\_\_\_\_

I. How much do your symptoms interfere with your activities?

**Daily Activities of Living:**

- ( ) None ( ) Rarely ( ) Often ( ) Most of the time ( ) Always

**Extra-curricular:**

- ( ) None ( ) Rarely ( ) Often ( ) Most of the time ( ) Always

J. Are you taking medication for THESE symptoms? YES / NO

**If yes, what and how much?**

K. Have you received any injections for these symptoms? YES NO If yes, on what date(s)?

The injection provided: ( ) Good relief ( ) Some relief ( ) No relief

L. What tests have been performed? ( ) X-ray ( ) MRI ( ) EMG ( ) CT ( ) Bone scan ( ) other \_\_\_\_\_

What are the test results? \_\_\_\_\_

M. Do you have any follow up testing scheduled? YES NO If yes, when? \_\_\_\_\_

( ) X-ray ( ) MRI ( ) EMG ( ) CT ( ) Bone scan ( ) other \_\_\_\_\_

N. When is your next scheduled follow up with your doctor who requested this therapy? \_\_\_\_\_

**PAST HISTORY of SIMILAR SYMPTOMS:**

A. Have you ever had the same kind of symptoms as you have now? ( )YES ( )NO If no, skip to next section.

B. If Yes, when? \_\_\_\_\_

C. How often do they recur? \_\_\_\_\_

D. How is this episode different?

- ( ) Severity  
( ) Irritability  
( ) Nature  
( ) Location

E. What made them better before? \_\_\_\_\_

**PAST MEDICAL HISTORY:**

- A. Any other accidents or injuries for which you saw a doctor? ( )YES ( )NO If yes, please list:  
\_\_\_\_\_
  
- B. ANY surgeries? (Heart, abdominal, any bone or joint or ligament or other?) ( )YES ( )NO If yes, please list:  
\_\_\_\_\_
  
- C. Other medications or problems diagnosed by a physician (Include Name of MD)? ( )YES ( )NO  
\_\_\_\_\_  
\_\_\_\_\_
  
- D. Have you HAD or do you NOW HAVE any of the following:
  - ( ) Arthritis ( ) Osteoporosis
  - ( ) Diabetes ( ) High blood pressure
  - ( ) Blood disorder\* ( ) Short of breath
  - ( ) Heart Condition ( ) Infectious disease\*
  - ( ) Hernia ( ) Bowel / bladder problems
  - ( ) Seizures ( ) Unexplained weight/energy loss\*
  - ( ) Dizziness ( ) Hearing or vision difficulty
  - ( ) Cancer ( ) Emotional problems
  - ( ) Sleeping difficulty ( ) Smoker – packs/day \_\_\_\_\_
  - ( ) Stroke /blood clot ( ) Currently pregnant
  - ( ) Severe/frequent headaches ( ) Other \_\_\_\_\_

• please explain/describe: \_\_\_\_\_

E. Are you currently under the care of a physician, psychiatrist or other healthcare professional in addition to the one prescribing your Physical / Occupational Therapy? ( )YES ( )NO If so, Who?  
\_\_\_\_\_

F. Have you ever had any Physical / Occupational Therapy or other body work prior to this occasion? YES NO  
If yes, please explain  
\_\_\_\_\_  
\_\_\_\_\_

G. Is there anything else you would like me to know about? If so, please explain.  
\_\_\_\_\_  
\_\_\_\_\_

H. What are your expectations to gain through therapy?

- ( )Decrease pain ( )Regain strength ( )Regain motion ( )Return to specific activity
- ( )Improve Function: \_\_\_\_\_ ( )Other \_\_\_\_\_

Thank you for taking the time to tell me about your symptoms. I look forward to discussing your symptoms with you.  
**Please sign below.**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Reviewed / Signed by Therapist:**

\_\_\_\_\_  
**Date**



# Irving Orthopedics & Sports Medicine

## Acknowledgement of Review of Notice of Privacy Practices

I have received and review this facility's Notice of Privacy Practices, which explains how my private health information will be used and disclosed. I understand that I am entitled to receive a copy of this document. By signing this form, I consent to the use and disclosure of my protected health information for the purpose of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance ton my prior consent. A photocopy or fax of this consent is as valid as the original.

In addition, I authorize the release of information to the individuals/entities identified below by name and relationship:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Facility Representative Signature

**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of review of our Notice of Privacy Practices, but were unable to do so for the following reason:

- \_\_\_\_\_ Patient/Guardian refused to sign
- \_\_\_\_\_ Communication barriers prohibited obtaining the acknowledgement
- \_\_\_\_\_ Other (please specify) \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_  
Facility Representative Signature