Active Rehab Center, Inc.

PHYSICAL THERAPY AND MASSAGE CLINIC

Initial Evaluation Questionnaire

Patient's Name: _____ Date: _____

Referring Physician: _____ Date Last Seen: _____

Your Height: _____ Your Weight: _____ lbs. Blood Pressure if Known: _____/_____

Has Your weight changed within last 6 months? Increased by _____ lbs. Decreased by _____ lbs.

Past Medical/Surgical History: _____

_____

_____

_____

_____

_____

_____

List of Your Medications: _____

_____

_____

Allergies – Please circle: Yes No. If yes, what kind? _____

Have You Fallen in the last 12 months? (Circle one) Yes No. If Yes, how many times? _____

Did Your Fall resulted in Injury? (Circle one) Yes No. If Yes, describe the nature of the injury: _____

_____

_____

Have You had an Auto or Work Injury? Yes No. If Yes, Please provide the DOI: _____

Describe the mechanism of accident: _____

_____

_____

_____

_____

28200 John R Rd, Madison Heights MI 48071
Tel: (248) 399-1060 Fax: (248) 399-3848
www.activerehabcenter.com

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Initial Evaluation Questionnaire

Patient's Name: _____ Date: _____

Please Indicate Your Pain Level on the Pain Scale from 0 – No Pain to 10 – Worse Possible Pain.

At Rest: 0 1 2 3 4 5 6 7 8 9 10 ☐

With Activity: 0 1 2 3 4 5 6 7 8 9 10 ☐

Please Circle the Type of Pain You Experience: ☐ Sharp, ☐ Dull, ☐ Constant, ☐ On and Off,

☐ Burning, ☐ Electrical, ☐ Throbbing, ☐ Stubbing, ☐ Localized, ☐ Radiating,

Other: _____

Pain Location: _____

Do You Experience: ☐ 1) Tingling ☐ 2) Numbness (Circle one that applies)

If Yes, Indicate Where: _____

Home Environmental Consideration

What are Your Living Arrangements? (Circle one that applies):

1 Single Level Home, ☐ 2 Multi Level Home, ☐ 3 Apartment, ☐ 4 Condo, ☐ 5 Assistive Living. ☐

Do You Live Alone? (Circle one that applies): ☐ Yes ☐ No

If You circled No, please specify, who do you live with? _____

Do You Have Steps 1) Inside Your House: Yes No. If Yes, how many? _____

Is there a railing? ☐ Y ☐ N

Do You Have Steps 2) Outside Your House? Yes No. If Yes, how many? _____

Is there a railing? ☐ Y ☐ N

Therapist Section to Fill In.

Neck: Flex _____ Ext _____ **LB**: Flex _____ Ext _____ **Knee**: Flex R_____ L_____

RFL _____ LFL _____ R Flex _____ L Flex _____ **Knee**: Ext R _____ L _____

R Rot _____ L Rot _____ R Rot _____ L Rot _____ SLR _____

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Shoul: Flex R_____ L_____ Ext R_____ L_____

Abd R_____ L_____ Add R_____ L_____

In Rot R_____ L_____ Ex Rot R_____ L_____

Hip ROM: Flex R_____ L_____ Ext R_____ L_____

Abd R_____ L_____ Add R_____ L_____

In Rot R_____ L_____ Ex Rot R_____ L____

Wrist: Flex R_____ L_____ Ext R____ L_____

Ul Dev R_____ L_Ra Dev R_____ L_____

Ankle: Flex R_____ L_____Ext R_____ L_____

Invr R_____ L_____ Ever R_____ L_____

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