THIBODAUX PHYSICAL THERAPY

Evaluation Form

Patient Name: _____ MR# _____ Date: _____

MEDICAL CONDITION/MEDICAL HISTORY

Pain Level: _____/10 Date of Injury/Onset/Surgery: _____

Mechanism of Injury/Type of Surgery: _____

Current Symptoms: _____

_____

_____

_____

Effect of Symptoms on Daily Activities: _____

Current/Past Conditions: ❑ Diabetes ❑ Hip Replacement ❑ Knee Replacement ❑ RSD ❑ COPD

❑ Rheumatoid Arthritis ❑ Osteo Arthritis ❑ Spondylosis with Myelopathy ❑ Spinal Stenosis

❑ Rotator Cuff Disorder ❑ Osteoporosis ❑ Dementia or Memory Loss ❑ Fracture of _____

Medical/Surgical History: _____

Previous Treatment: _____

Tests: ❑ MRI: _____ ❑ CT Scan: _____ ❑ X-ray: _____

Medications: ❑ See list below ❑ See attached list

_____

_____

_____

Other: _____

_____

_____

DEMOGRAPHIC BACKGROUND

Where do you live? ❑ Private Home/Apartment ❑ Assisted Living/Group Home ❑ Long-Term Care Facility ❑ Other

Do you need to navigate stairs regularly? ❑ Yes ❑ No If yes, how many? _____

With whom do you live? ❑ Spouse/Significant Other ❑ Alone ❑ Child/Children ❑ Group Setting ❑ Personal Care Attendant

Are you currently in the living environment you were prior to your injury or surgery? ❑ Yes ❑ No

If no, do you have a desire or need to return? ❑ Yes ❑ No

Work Status: ❑ Full time, outside home ❑ Full time, in home ❑ Part time, outside home ❑ Part time, in home

❑ Working with modification due to current injury/symptoms ❑ Unemployed ❑ Retired

Occupation includes: ❑ Sitting at a computer or prolonged computer use ❑ Manual labor ❑ Homemaker

If homemaker, caregiver for small children (<6 yrs old)? ❑ Yes ❑ No

Hobbies: _____

Patient Goals: _____

_____

Other: _____

_____

_____