COMPLETE REHAB CLIENT EVALUATION QUESTIONAIRE

1. WHEN DID YOUR PROBLEMS BEGIN?_____

2. BRIEFLY DESCRIBE WHAT HAPPENED_____

_____

3. HAVE YOU RECEIVED THERAPY PRIOR TO THIS VISIT? YES / NO

   IF SO WHEN? WHERE?

4. HAVE YOU HAD SURGERY FOR THIS PROBLEM? YES / NO

   IF SO WHEN? WHERE?

5. WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM

   _____

6. "BECAUSE OF THIS PROBLEM, I HAVE TROUBLE WITH" (CIRCLE)

   STANDING, BALANCE, WALKING, ENDURANCE, LIFTING

   TRANSFERS, BATHING, DRESSI NG, HOUSEKEEPING,

   COOKING, YARD WORK, PERFORMING JOB, RECREATIONAL

   ACTIVITIES, SLEEPING, OTHER _____.

7. WHEN IS YOUR NEXT VISIT TO THE DOCTOR?_____

8. IS YOUR PAIN CONSTANT?_____

9. DO YOU HAVE NUMBNESS OR TINGLING?

   IF SO WHERE _____

10. WHAT (IF ANYTHING) EASES YOUR PAIN?_____

11. WHAT MAKES YOUR PAIN WORSE_____

12. DOES YOUR PAIN KEEP YOU AWAKE AT NIGHT?_____

13. ANY TESTS FOR THIS PROBLEM (MRI, CT SCAN , EX RAYS, ETC-

_____

14. ARE YOU: (CIRCLE) EMPLOYED, RETIRED, STUDENT , UNEMPLOYED

15. (IF APPLICABLE) LAST DAY WORKED?_____

16. JOB REQUIREMENTS (BRIEF DESCRIPTION)

_____

Following is a chart describing a level of pain. We need to know where you rate your pain in 3 ways. The best or least pain you experience, the highest or worst pain you experience, and where you rate you pain at this moment. We realize pain can sometimes be a difficult thing to rate, but please try your best.

10. Excruciating, you need to call emergency services

9. Very, very strong pain

8. Very strong pain

7. Strong pain

6. Somewhat strong pain

5. Moderate pain

4. Somewhat moderate pain

3. Light pain

2. Very light pain

1. Minimal pain

0. No pain at all

Least _____

Worst_____

Current_____

My Pain is mainly located _____

17. Medical History

		YEAR			YEAR			YEAR
Anemia	YES/NO		Glaucoma	YES/NO		Lung Disease	YES/NO	
Angina	YES/NO		Heart Attack	YES/NO		Migraines	YES/NO	
GI Ulcers	YES/NO		Gout	YES/NO		Neuropathy	YES/NO	
Arthritis	YES/NO		Heart Disease	YES/NO		Parkinson's Disease	YES/NO	
Asthma	YES/NO		Heart Murmur	YES/NO		Phlebitis	YES/NO	
Blood Clots	YES/NO		Hepatitis	YES/NO		Prostrate Disease	YES/NO	
Cancer	YES/NO		Hiatal Hernia	YES/NO		Rheumatic Fever	YES/NO	
Circulation	YES/NO		High Blood Pressure	YES/NO		Seasonal Allergies	YES/NO	
Depression	YES/NO		High Cholesterol	YES/NO		STD's	YES/NO	
Diabetes	YES/NO		Infectious Disease	YES/NO		Stoke (CVA)	YES/NO	
Epilepsy	YES/NO		Kidney Disease	YES/NO		Thyroid Disease	YES/NO	
Fibromyalgia	YES/NO		Liver Disease	YES/NO		Tuberculosis	YES/NO	

18. Any Other significant Medical History: _____

_____

_____

19. LIST CURRENT MEDICATIONS (OR ATTACH LIST):

20. WHAT IS YOUR GOAL FOR THERAPY? _____

21. CIRCLE WHERE YOUR PAIN OR INJURY IS LOCATED: