ALHAMBRA VALLEY
PHYSICAL THERAPY
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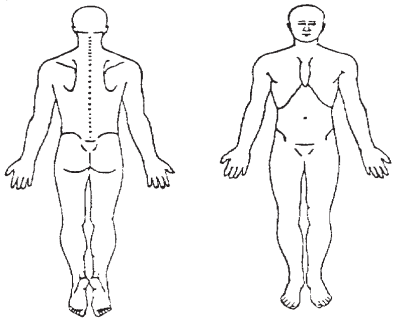
EVALUATION AND PLAN OF CARE

Patient's Name/Signature _____ Date:_____

Occupation_____ Hobbies/Sports _____

1. Please Shade in the area where your symptoms are:



Are you feeling: Pain, Stiffness, Numbness, Tingling, Weakness (circle)

Circle the number that best corresponds to your pain *(0 = no pain, 10 = excruciating pain)*
at its best 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
at its worst 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

2. What is difficult for you to do because of your symptoms?
- ☐ Lying
- ☐ Sitting
- ☐ Stand up from sitting
- ☐ Standing
- ☐ Bend forward
- ☐ Walking
- ☐ Lifting
- ☐ Reaching
- ☐ Other _____

3. What helps to ease your symptoms?
- ☐ Change position
- ☐ Ice
- ☐ Heat
- ☐ Medications
- ☐ Massage
- ☐ Other _____
- ☐ Nothing

4. Do you wake at night because of your symptoms? Yes No
Times each night _____ # Nights each week _____
How do you get back to sleep:
- ☐ Change position
- ☐ Get up and move
- ☐ Take Medications
- ☐ Other _____

5. When do your symptoms feel the worst?
- ☐ Morning ☐ Afternoon ☐ Evening ☐ Night (in bed)
- ☐ Same all day ☐ Depends only on what I am doing

6. What would you like to do that you are not able to do now because of your symptoms? _____

7. Which of the following OVER THE COUNTER medications have you taken in the last week?

Yes	No	Aspirin	Yes	No	Decongestants
Yes	No	Tylenol	Yes	No	Antihistamines
Yes	No	Advil/Motrin/Ibuprofen	Yes	No	Antacids
Yes	No	Laxatives	Yes	No	Other

Do you take steroid (ie prednisone) or blood thinning medication? Y N
Have you in the past? Y N

Please list any PRESCRIPTION Medications you are currently taking and the dosage: _____

8. Yes No Do you smoke cigarettes? # of packs a day _____
9. Yes No Female patients - are you pregnant?

10. Patient History
a. When did your current problem start? _____
b. Please describe how your symptoms first started: _____
c. Are you currently unable to work because of your problem? Y N
d. Since it started, is it: ☐ Better ☐ Worse ☐ Same
e. Have you had any medical tests for this problem? Please list: _____
f. Have you had a problem in this area before? Y N
Please describe _____
g. What treatment did you receive for the past problem _____
Was it helpful? Y N

11. List any surgeries or conditions for which you have been hospitalized: _____

12. Have you recently had problems with:

Yes	No	Unexplained weight loss/gain	Yes	No	Difficulty with urination/bowel movements
Yes	No	Fever/chills/night sweats	Yes	No	Increase in symptoms when you cough or sneeze
Yes	No	Nausea/vomiting			
Yes	No	Headaches/dizziness/vertigo/visual disturbances			
Yes	No	Difficulty keeping your balance while standing/walking			
Yes	No	Fatigue			
Yes	No	Weakness			
Yes	No	Numbness or tingling			

13. Have you EVER been diagnosed with any of the following?

Yes	No	Heart problems	Yes	No	Diabetes
Yes	No	Circulation problems	Yes	No	Depression
Yes	No	High blood pressure	Yes	No	Tuberculosis
Yes	No	Asthma	Yes	No	Stroke
Yes	No	Emphysema/Bronchitis	Yes	No	Kidney disease
Yes	No	Thyroid problems	Yes	No	Anemia
Yes	No	Chemical dependency	Yes	No	Epilepsy
Yes	No	Rheumatoid arthritis			
Yes	No	Other arthritic conditions (Gout, Psoriatic)			
Yes	No	Cancer, if YES, describe what kind _____			
Yes	No	Other _____			

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Blood Pressure
_____/_____

☐ Discussed patient's medication

Have you had 2 or more falls within the past year? Y N

If you have fallen, have you sustained any injuries? Y N

Pain Intensity -
Circle the number that best corresponds to your pain *(0 = no pain, 10 = excruciating pain)*
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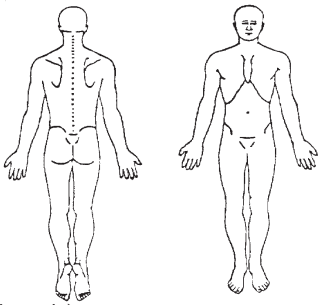
at its worst 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10



Goals discussed with patient ☐