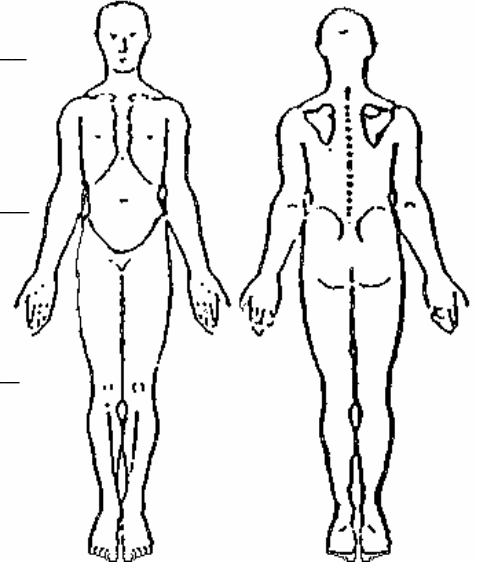


**SUBJECTIVE EVALUATION FORM**

**PATIENT NAME:** \_\_\_\_\_

AREAS OF PAIN



1. DATE OF INJURY OR ONSET OF SYMPTOMS: \_\_\_\_\_
2. TESTS relating to this condition: (circle all that apply)  
X-Ray, MRI, CT, EMG, Bone Scan, Arthrogram  
Results: \_\_\_\_\_
3. DESCRIBE YOUR PAIN (indicate location on body chart to the right):  
Sharp, Dull, Ache, Shooting, Stiffness  
Other \_\_\_\_\_
4. RATE YOUR PAIN within the last 24 hours:  
(0 = NO PAIN, 10 = WORST PAIN): \_\_\_\_\_
5. DO YOU EXPERIENCE ANY: (circle)  
Numbness, Tingling, Weakness, Cramping
6. WHAT INCREASES SYMPTOMS: \_\_\_\_\_
7. WHAT DECREASES SYMPTOMS (POSITION/ACTIVITY): \_\_\_\_\_
8. DOES THIS CONDITION KEEP YOU FROM SLEEPING? Yes or No
9. PLEASE LIST MEDICATIONS related to this condition: \_\_\_\_\_  
\_\_\_\_\_  
Other medications: \_\_\_\_\_  
\_\_\_\_\_
10. ARE YOU ABLE TO WORK? Yes or No      If yes, list restrictions if any: \_\_\_\_\_
11. ANY PAST PROBLEMS OF THIS NATURE ? \_\_\_\_\_
12. HAVE YOU RECEIVED OTHER TREATMENT FOR THIS CONDITION IN THE PAST? Yes or No  
If yes, please describe: \_\_\_\_\_
13. PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:  
\_\_asthma                      \_\_hearing or vision problems      \_\_chest pains                      \_\_arthritis  
\_\_frequent headaches      \_\_heart trouble                      \_\_latex allergies                      \_\_pregnant  
\_\_high/low blood press      \_\_diabetes                              \_\_seizures                              \_\_pacemaker/defibrillator  
\_\_fainting                              \_\_cancer
14. ANY OTHER CONDITIONS THE THERAPIST SHOULD KNOW ABOUT? \_\_\_\_\_
15. WHAT DO YOU HOPE TO ACHIEVE THROUGH THERAPY? \_\_\_\_\_

\_\_\_\_\_  
PATIENT SIGNATURE                                      THERAPIST SIGNATURE FOR REVISIONS                                      DATE SIGNED