3620 Harlem Rd, Ste 2 * Cheektowaga, NY 14215 * Phone: 716-446-9500 * Fax: 716-446-9501

PHYSICAL THERAPY INITIAL EVALUATION

Patient Name: _____
Address: _____
City/ST/Zip: _____
Phone #'s: Home:_____
Other: _____
(please indicate Work/Cell/etc)
Date of Birth: _____
SS #: _____
Employer: _____
Marital Status: _____

Date of Evaluation: _____
(Today's date)
Referring Physician: _____
Address: _____
_____
Phone: _____
Fax: _____

Emergency Contact: Name _____
Phone #: _____ Relationship: _____

Type of Insurance covering this injury (Please Circle): Commercial (Personal) / Workers Comp / No-Fault / Medicare / Medicaid / None

Insurance Carrier: _____ ID#_____

Policy Holder: Name _____ Date of Birth_____ Relationship _____

Secondary Ins. Carrier: _____ ID#_____
(Please list your Commercial (personal) insurance here if workers comp or No fault)
Policy Holder: Name_____ Date of Birth_____ Relationship_____

*****OFFICE USE ONLY BELOW THIS LINE***OFFICE USE ONLY BELOW THIS LINE*****

DIAGNOSIS: CODE:

HISTORY:
HPI / onset :_____
_____
PMH: _____
PSH: _____
Medications: _____
Allergies: _____
Hx of Therapy:_____

SUBJECTIVE:
Chief Complaint:_____
_____

Radiculopathy/Referred Pain : ( ) No ( ) Yes / Describe: _____
_____

Quality of pain: (please circle all that apply) sharp dull achy burning stabbing searing throbbing

Current pain level (scale of 0-10): 0 1 2 3 4 5 6 7 8 9 10 Pain level at Best: (use scale 0-10)_____ Worst:_____

When is pain best?: Worst?:

Alleviating Factors: Aggravating Factors: