EVALUATION SHEET

Patient Name: _____ Date of Birth: _____

Date of Evaluation: _____ Injury/Onset Date: _____

Diagnosis: _____

Physician who referred you here, if applicable: _____

What was your prior level of function? _____

Please explain the reason why you are here: _____

What is your approximate Weight _____ Height _____

Instructions: On a scale from 0 to 10, place a **vertical line** | on the scale to rate levels of **Pain Intensity and Frequency**

INTENSITY: How severe is the pain?

None Mild Moderate Severe Worst Possible

0 1 2 3 4 5 6 7 8 9 10

FREQUENCY: How often do you have the pain?

Seldom Constant Pain

0 1 2 3 4 5 6 7 8 9 10

What activities increase the pain? _____

What activities decrease the pain? _____

Patient Goals: What would you like to be able to do as a result of therapy?

1. _____ 2. _____ 3. _____

In the chart below, please indicate the location of your pain.