flow Total Wellness

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INITIAL EVALUATION

The following is a very important part of the evaluation process. Please fill out this form as specific as possible to provide your therapist with a clear picture of your present pain and functional status. Thank you!

Personal Information: *(Please print clearly)* **Date:**______________________

Name:____
Last First Middle Initial

Home Address:____
Street City State Zip

Telephone: Home: (____)___________Mobile: (____)___________Work: (____)_____________

Date of Birth: __________ Age: ____ Sex: ____ E-mail Address: ________________________

Occupation: ______________________________ Currently Working: _____ Hours/Wk: _______

Medical Information:

PrimaryPhysician/Practice:____

Address: ____ Phone: (____)____________
Street City State/Zip

Referring Physician or Therapist:____

Address: ____ Phone: (____)____________
Street City State/Zip

How did you hear about Flow Total Wellness?____

1. What is the PRIMARY complaint that brings you to Flow Total Wellness today? ___________

   ____

   SECONDARY complaint? ____

   ____

   As a result, I am having difficulty with: ____

   ____

   Are you experiencing pain as a result of these symptoms? __________________________

2. When (date) and how did your symptom(s) begin?___________________________________

3.Have you received any of the following treatments(s) for this condition?

	Yes	No	How Long?	Helpful / Manage / Resolve
Physical Therapy	____	____	______________	___________________________
MFR	____	____	______________	___________________________
Chiropractic Care	____	____	______________	___________________________
Acupuncture	____	____	______________	___________________________
Trigger Point Injection(s)	____	____	______________	___________________________
Other____________________	____	____	______________	___________________________

4. Please check any / all illnesses you have either had in the past or currently have?

______ Cardiovascular Disease ______ High Blood Pressure ______ Diabetes (1 or 2)

______ Arthritis (Osteo / Rheum) ______ Kidney / Renal Disease ______ Multiple Sclerosis

______ Asthma / Difficulty Breathing ______ Congestive Heart Failure ______ Fibromyalgia

_______ Dizzy / Vertigo ______ Hepatitis / Liver Disease ______ Epilepsy / Seizures

______ Thyroid Condition (Hypo / Hyper) _____ Neurological Condition ______ Eating Disorder

______ Drug or Alcohol Abuse ______ Depression ______ Anemia

______ Osteoporosis ______ Chronic Infection(s) ______ Lupus

______ Heart Murmur ______ Varicose Veins ______ Blackouts

______ Weight Changes ______ Metal Implants (if so, where_________________________)

______ HIV / AIDS ______ Stroke or Heart Attack (if so, when____________________)

______ Migraine / Headaches – (if so, how frequent____)

______ Broken Bone(s) – (if so, where and when____)

______ Cancer – Type __________________________ Location(s) _______________________________

Year _________ Status ____

______ Allergies – (Latex, Food Seasonal, Medicine) ____

____

______ Other – (Please specify) ____

____

____

5. Do you have a pacemaker, internal defibrillator, insulin pump, or any other implanted medical device?

____

____

6. List past medical history with dates for all surgeries, accidents and other traumas.

____

____

____

____

7. Please list ALL medications you are presently taking, the dose, the reason for each medication and the effectiveness. (ie: Prozac for Depression, Ultram for Pain, Accupril for HBP…)

Medication Treatment of Dose-Amount / Day Effectiveness

____

____

____

____

____

____

8. Please list all supplements, herbal and homeopathic remedies you are currently taking.

____

____

____

9. Are you currently pregnant or is there a possibility you may be pregnant? _________________

10. Do you smoke? _____________________________ How much? ______________________

11. Do you currently exercise and/or participate in any sports? ___________________________

Activity # of Times per Wk / Mo Duration of Time

____

____

____

____

12. Do you experience any discomfort, shortness of breath or pain with these activities? _______

13. In general, how would you characterize your lifestyle?

_____ Very Active _____ Active _____ Average _____ Somewhat Active _____ Inactive

14. Please review the following 'symptoms'.

Place an "M" in front of each item that you experience at least MONTHLY.
Place an "W" in front of each item that you experience on a WEEKLY or more frequently.

_______ Headaches
_______ Chest pain, tightness
_______ Numbness, tingling in arms and legs
_______ Sweaty palms
_______ Excessive perspiration
_______ Can't keep warm enough
_______ Coughing
_______ Stuffy nose, congestion
_______ Nosebleeds
_______ Earache or ringing noise in ears
_______ Common colds
_______ Sore throat
_______ Asthma or shortness of breath
_______ Hay fever or allergies
_______ Sore, aching muscles
_______ Stiff or tender points
_______ Back problems
_______ Trembling / twitching muscles
_______Skin rashes, eruptions
_______ Grinding of teeth (TMJ)
_______ Dry mouth
_______ Mouth sores
_______ Trouble falling asleep
_______ Trouble sleeping through the night
_______ Awaken too early in morning
_______ Excessive drowsiness during day
_______ Periods of extreme fatigue
_______ Feeling faint or dizzy
_______ Feeling tense or nervous
_______ Difficulties w/family and friends
_______ Worrisome thoughts
_______ Recurring bad thoughts
_______ Thoughts of suicide
_______ Fearful of persons or places
_______ Feeling of inadequate / unable to cope
_______ Feeling of guilt or failure
_______ Uncontrolled crying or sadness
_______ Easily annoyed or irritated
_______ Anxiety about life
_______ Blushing / Flushed face
_______ Eyestrain or discomfort
_______ Eye irritation or inflammation
_______ Visual Disturbances – blurry
_______ Stomach cramps
_______ Heartburn / Indigestion
_______ Nausea or vomiting
_______ Frequent urination
_______ Incomplete urination
_______ Pain urination
_______ Urinary leakage
_______ Bowel leakage
_______ Diarrhea
_______ Constipation
_______ Bowel Irregularity
_______ Frequent laxative use
_______ Uninterested in sex relations
_______ Unable to enjoy sexual activity
_______ Menstrual difficulties
_______ Pre-menstrual syndrome
_______ Breast tenderness
_______ Hot flashes
_______ Water retention
_______ Over-eating, bingeing
_______ Lack of appetite
_______ Excessive alcohol abuse
_______ Other substance abuse
_______ Other: ____________________________
____

15. If sleep is a problem, do you have troubles falling asleep? ______________________________

Is your sleep restful? ____
Do you find it difficult to lay down? ____
Do you have difficulty sitting up from a lying down position? _________________________
Do you have difficulty changing positions in bed? _________________________________
How many times do you wake up during the night? ________________________________
How long does it take you to fall back asleep? ____________________________________

16. On a *GOOD* day, please rate the *INTESITY* of your pain.

"0" = NO pain, "5" = moderate pain, "10" = UNBEARABLE pain. ____________________

Please rate the *FREQUENCY* of your pain.
"0" = Never, "5" = Intermittent, "10" = Constant pain. ______________________________

17. On a *BAD* day, please rate the *INTENSITY* of your pain.
    “0” = NO pain, “5” = moderate pain, “10” = UNBEARABLE pain. ____________________

    Please rate the *FREQUENCY* of your pain.
    “0” = Never, “5” = Intermittent, “10” = Constant pain. ______________________________

18. Using the same “0-10” scale, rate your *OVERALL* pain.

    At its worse ______ At its best _______ Most of the time ______ Night / Sleeping ______

19. What time of day are your symptoms the *WORST*? ________________________________

20. What time of day are your symptoms the *BEST*? ___________________________________

21. What activities *INCREASE* your pain? ____

22. What activities *DECREASE* your pain? ____

23. Please estimate the amount of time, on average / day, you spend on the following activities:

    ______ Sleeping　　______ Driving　　_____ Household Chores

    ______ Working　　______ Sitting at desk　　_____ Standing in Place

    ______ Computer Work　　______ On the phone　　_____ Sports / Hobbies

    ______ Other ____

24. Do you need to rest during the day? _______ If so, how long? _________________________

25. How much time can you tolerate being in a vertical position each day? ____________Hour(s)
    (Include sitting, standing, driving and walking)

26. How much time can you tolerate being in a horizontal position each day? __________Hour(s)
    (Include reclining, laying down, sleeping)

27. Please complete the following sentences.

    I can walk for ______ minutes before needing to rest.
    I can stand for ______ minutes before needing to rest.
    I can sit for ______ minutes before needing to change positions or get up.

28. Do you have trouble getting up from a chair? ____

29. Do you have trouble putting on your shoes and socks? _______________________________

30. Do you have difficulty climbing stairs? ____

31. Please list all the tasks and/or activities that you have difficulty performing. Include the amount of time that you are able to perform each activity and/or task. If you are unable to perform an activity and/or task, then your tolerance would be "0".

Task / Activity	Tolerance (Minutes / Hours)
1. ____	_______________________
2. ____	_______________________
3. ____	_______________________
4. ____	_______________________
5. ____	_______________________

32. On a *GOOD* day, how would you rate your *FUNCTIONAL ABILITY*?

_____ Very Active _____ Active _____ Average _____ Somewhat Active _____ Inactive

33. On a *BAD* day, how would you rate your *FUNCTIONAL ABILITY*?

_____ Very Active _____ Active _____ Average _____ Somewhat Active _____ Inactive

34. Is there anything else you would like to share with your therapist? _______________________

____

____

____

35. What are your goals for therapy? Please be specific.

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TO THE BEST OF MY KNOWLEDGE, THE INFORMATION I HAVE SHARED ABOVE IS COMPLETE AND TRUE. IF MY MEDICAL / HEALTH STATUS CHANGES, I WILL INFORM MY THERAPIST IMMEDIATELY.

____ _________________________

Patient Signature Date