FUNCTIONAL ASSESSMENT

ANSWER THE FOLLOWING QUESTIONS, IF APPLICABLE.

1. Do you find it difficult to change positions? Describe_____
   _____
   Do you find it difficult to lie down? Yes_____ No_____
   To come to a sitting position from lying down? Yes_____ No_____
   Do you have trouble getting up from a chair? Yes_____ No_____
2. Do you have trouble putting on your shoes and socks? Yes_____ No_____
3. I walk for _____ minutes before needing to rest.
4. I stand for _____ minutes before needing to sit.
5. I sit for _____ minutes before needing to change positions/get up.
6. Do you have difficulty stair climbing? Yes_____ No_____
7. How often during the day do you need to lie down and rest? _____
8. Do you engage in regular exercise? What type and how often? _____
   _____
   Are you able to exercise now? Yes_____ No_____
9. Do you have discomfort, shortness of breath or pain with exercise? _____
10. Do you work? Yes_____ No_____ What is your Occupation?_____
11. In general, your lifestyle is: 1 active 2 3 average 4 5 inactive
12. Do you presently see a chiropractor? No_____ Yes_____
    Other Physical Therapists? No_____ Yes_____ Whom:_____
13. WHAT ARE YOUR GOALS FOR THERAPY? _____
    _____
    _____

Signature: _____ Date: _____/_____/_____

MEDICAL HISTORY

Check the box if you have had any of the following:

_____Diabetes	_____Varicose Veins	_____Neurological problems
_____Rheumatic fever	_____Circulatory problems	_____Stroke
_____Heart murmur	_____Lung disease	_____Broken bones (fracture)
_____Heartdisease/pacemaker	_____Epilepsy/seizures	_____Kidney disease
_____Migrane headaches	_____Cancer	_____Metal implants
_____Osteoporosis	_____Arthritis	_____Other…explain_____

List any significant hospitalizations and surgical procedures/reasons/dates:_____

_____

_____

List any medications that you are presently on: _____

_____

Do you have any skin or medication allergies? Yes_____ No_____ If so, which? _____

_____

Is there a chance you may be pregnant at this time? Yes_____ No_____

Do you smoke? _____cigar/cigarettes/pipe. How much? _____ When did you quit? _____

BRIEFLY GIVE HISTORY OF ILLNESS YOU ARE NOW REFERRED TO PHYSICAL THERAPY FOR. ALSO INCLUDE SYMPTOMS._____

_____

_____

Is the pain constant/intermittent?_____

Does the pain radiate? Where? _____

What makes it feel better? _____

What makes it feel worse? _____

Describe the pain: _____Dull ache _____Stabbing _____Pins & Needles _____Burning _____Numbness

Where? _____

Rate the pain intensity on a scale of 0-10 (10 the worst pain):

0 1 2 3 4 5 6 7 8 9 10

No pain Excruciating pain

USING THE DIAGRAM AT THE RIGHT
SHOW THE LOCATION OF PAIN