INITIAL EVALUATION SUBJECTIVE REPORT

Name _____Date _____

The following is important for the documentation process.
Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

1. What is the primary complaint that brings you to Arancia PT for an intensive today?

Secondary complaint?

As a result, I am now having difficulty with:

Are you currently experiencing pain as a result of these symptoms? _____

2. Please rate the intensity of your pain with "0" being no pain, "5" being moderate pain, and "10" being unbearable pain.

Your ***Pain Intensity*** Rating: _____

3. Please rate the frequency of your pain with "0" being never, "5" being intermittent, and "10" being constant.

Your ***Pain Frequency*** Rating: _____

4. More specifically, rate your pain using the same "0" to "10" scale.

At its worst _____
At its best _____
Most of the time _____
Night (sleeping) _____

5. At what time of day are your symptoms the worst? _____

At what time of day are your symptoms the best? _____

6. What activities increase your pain? _____

What activities decrease your pain? _____

7. Do you engage in regular exercise? Yes / No

What type and how often? _____

_____

Are you able to exercise now? Yes / No

Do you have discomfort, shortness of breath, or pain with exercise? _____

_____

In general, your lifestyle is: 1 2 3 4 5
Active Average Inactive

8. If there is interruption of bladder or bowel function, please explain? _____

_____

If there is any unusual interruption of menstrual functions, please explain? _____

_____

If sexually active, is there pain associated? How often? _____

_____

9. If sleep is a problem, answer these questions:

Do you have trouble falling asleep? Yes / No
Is your sleep restful? Yes / No
Do you find it difficult to lie down? Yes / No
To come to a sitting position from lying down? Yes / No

Do you find it difficult to change positions in bed? _____

How many times do you wake in the night? _____

How long before you fall back to sleep? _____

10. Daily Activities and functions

Please estimate the amount of time, ***on average***, you spend in each of the following activities per day.

Sleeping _____ Working _____

Household Chores _____ Sitting at desk _____

Standing in place _____ Driving _____

Computer Work _____ Talking on phone _____

Playing (specify sports & hobbies) _____

Other _____

(If limited) How much total time do you tolerate being in a **vertical** position per day? (e.g. sitting, standing, walking, driving) _____ hour(s)

If you need to rest during the day, how often? _____
And what is the total time? _____ hour(s)

How much total time do you tolerate being in a **horizontal** position per day? (e.g. reclining, laying down, sleeping) _____ hour(s)

I walk for _____ minutes before needing to rest.

I stand for _____ minutes before needing to sit.

I sit for _____ minutes before needing to change positions/get up.

Do you have trouble getting up from a chair? Yes / No

Do you have trouble putting on your shoes and socks? Yes / No

Do you have difficulty climbing stairs? Yes / No

11. *If any daily activities are limited, answer this question.*

List all the **Tasks/Activities** that you have difficulty performing and your tolerance (minutes/hours) for each task/activity. If you are no longer able to perform an activity, your tolerance would be "0".

Task/Activity	Tolerance
1._____	1._____
2._____	2._____
3._____	3._____
4._____	4._____
5._____	5._____

12. Functional Ability

On the line scale below, place a check mark to indicate your level of daily functional ability.

	Inactive		**Normal**
On a good day	0%	_____	100%
On a bad day	0%	_____	100%

13. Patient Goals

List the activities that you would like to be able to do as a result of therapy in general and please expand on specific intentions for your days / weeks of intensive.

Activity	Duration/How Often	By When
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Other Goals? _____

_____

_____

14. List ALL medications which you are currently taking, the problem for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).

Medication	for treatment of	Dose/Amt. per day	Effectiveness