PROACTIVE physiotherapy
Professional treatment for Active Health
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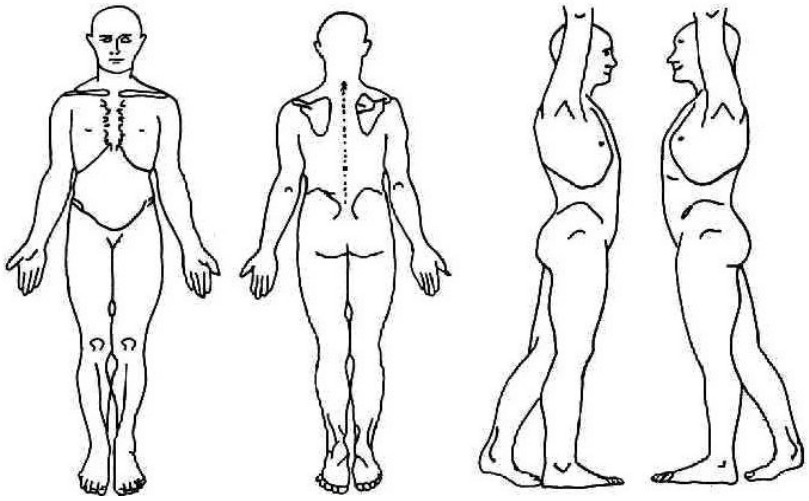
INITIAL ASSESSMENT FORM		Date:	
Patient's Name:		Dr's Name:	

What is your main reason for attending today?

How long have you had the problem this time?

Please shade the body chart in the areas you experience pain or discomfort. Not just the pain you are coming for today, but any other areas.

Mark the chart with crosses in the areas you feel pins and needles or numbness



List any activities that make your problem worse.

List any things that helps ease your problem.

What are your goals / hopes in attending physiotherapy treatment today?

Describe your general health:(Please Tick)	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Do you smoke? ☐ Yes ☐ No		How many per day?		

Please list any major illnesses, accidents, surgery, diseases and approximate dates of these:

Dates:	Details:

PLEASE TURN OVER

Please list your current medications, both medical and natural:		
Do you participate in any form of exercise:	☐ Yes	☐ No
Please list the type and the frequency per week.		

How do you spend mostly spend your day at work?				
☐ Sitting	☐ Standing	☐ Moving	☐ Lifting	☐ Other_____.

When you are not working, how do you spend your time? Please list hobbies, pastimes etc.		
Have you visited any other health practitioners with this particular problem?	☐ Yes	☐ No
If so, what kind of practitioner? Did you gain any relief from the problem?		
1	☐ Yes	☐ No
2	☐ Yes	☐ No
3	☐ Yes	☐ No
4	☐ Yes	☐ No
Have you ever experienced a problem like this before in the past?	☐ Yes	☐ No
If so, when?		
Did you receive any treatment for this previous incident?	☐ Yes	☐ No
If so, what was the treatment and did it help?		
1	☐ Yes	☐ No
2	☐ Yes	☐ No
3	☐ Yes	☐ No
4	☐ Yes	☐ No