Functional Physical Therapy
3441 Tennyson St.
Denver, CO 80212
303-941-0664

INITIAL SELF EVALUATION FORM

Name_____ **Date**_____

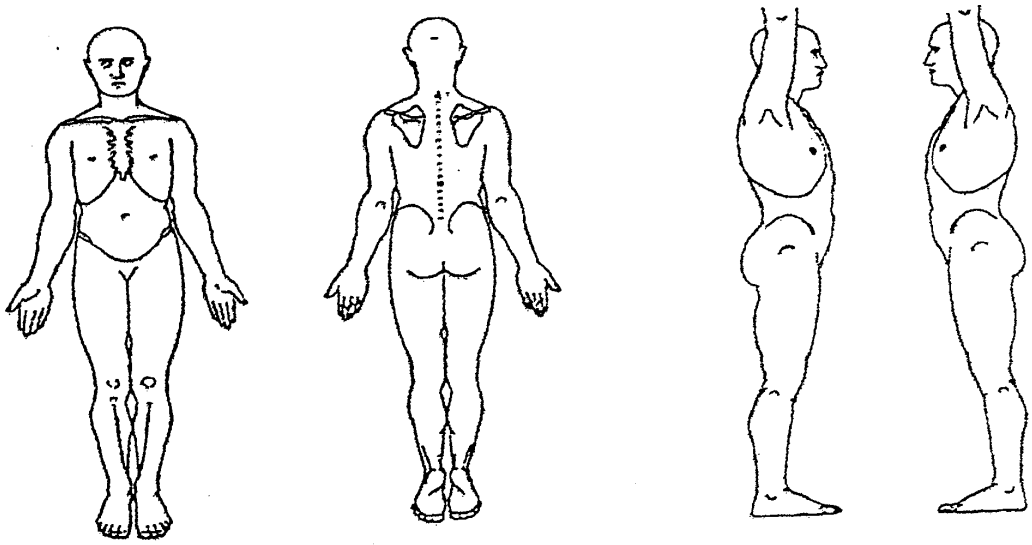
Please tell us about yourself, so that we can serve you better. If you have difficulty answering any question, or if it doesn't apply to you, just leave it blank. You will have ample opportunity to clarify or explain any of your answers during your evaluation and treatment sessions.

Who referred you to us?_____
What is your reason for seeking therapy? _____

_____

Please mark or shade in any areas where you have been experiencing discomfort. You can label each area with one or more descriptor from the following list:

Severe	**Sharp**	**Burning**	**Aching**
Moderate	**Dull**	**Throbbing**	**Stabbing**
Numbness/Tingling	**Weakness**	**Radiating (indicate direction with arrow)**	



List & rate each symptoms you have been experiencing. Rate on a 0-10, 0 is no pain- 10 the worst pain you can imagine.

A._____ **0 1 2 3 4 5 6 7 8 9 10**
B._____ **0 1 2 3 4 5 6 7 8 9 10**
C._____ **0 1 2 3 4 5 6 7 8 9 10**
D._____ **0 1 2 3 4 5 6 7 8 9 10**

When did your symptoms begin? _____

What do you think causes your symptoms? _____

List any injuries or surgeries including dates (continue on back if necessary) _____