Valens Physical Therapy & Sports Performance
Initial Evaluation Questionnaire

Name: ______________________________ Date of Birth: _____________________ Gender: M F
Occupation ____________________________ Primary Care Physician: ______________________________

How did you here about us? MD _______ Friend ________ Insurance ________ Other: ______________

Have you been out of work due to your injury? Y N *if yes, when did you return to work:*

Please describe your reason for seeking physical therapy? ____

____

____

What caused your pain or problem? ____

When did your pain or problem begin? ____

Is your pain getting worse, better, or staying the same? ____

Have you ever experienced this pain or problem before? Y N *if yes, please explain.*

____

Please rate your pain from 0 – 10 (0 no pain & 10 maximum) ________/10 @ worst ________/10 @ best

Are you taking any medication for this pain or problem? Y N *if yes, please list* _________________________

____

Does this medication help? Y N *if yes, please explain, or state any comments or concerns regarding this*

____

Have you had any x-rays, MRI's, or CT scans? Y N *if yes, please explain any known results. If you have a copy of any reports, please provide them.* ____

____

List any previous musculoskeletal injuries ____

____

Past Medical History

Condition	*Yes*	*No*	
Diabetes	___	___	
Thyroid Problems	___	___	
Heart Condition	___	___	
Heart Attack	___	___	
Pacemaker	___	___	
Autoimmune Disease	___	___	
Urinary frequency	___	___	
Weight loss/gain > 10Ibs	___	___	*(Recent)*
Depression	___	___	
Anxiety	___	___	
Stroke	___	___	
Cancer	___	___	

Are you currently experiencing pain that awakes you from sleep? Y N

Are you pregnant? Y N

Any recent medical (non-orthopedic) surgeries?
Y N *Please list* _______________________
____
____

Other: _________________________________

Are you Allergic to any medications? If so, please list: ____

What are your goals for Physical Therapy?

____

____