UK HealthCare

- University of Kentucky A.B. Chandler Hospital
- UK HealthCare Good Samaritan Hospital
- UK HealthCare Ambulatory Services
- UK Dental and Oral Health Clinics

SPORTS REHAB NEW PATIENT SELF-ASSESSMENT

Name:______________________________ **Age:**________ **Employment:** ____________________

Do you have a Latex allergy? YES No **Contact Phone** ____________________

Have you fallen in the last 3 months? Yes No **Emergency Phone number:** ____________________

Have you had Physical Therapy within the past 12 months?______ **If yes, Where?** ____________________

Chief complaint: ____

When did your symptoms begin? ____

What activities do you have difficulty performing? ____

____

Do your symptoms interfere with your work? No Yes ____________________

Does your pain awaken you from your sleep that is not caused by movement? No Yes ____________________

Do you have pain with coughing or sneezing? No Yes Do you have pain in the morning? No Yes

What makes your symptoms Worse?______________________ Better? ____________________

Is your pain constant? No q Yes q MRI date, if applicable: __________ X-ray date, if applicable: __________

Surgical date, if applicable: ____

Please list current medicines:____

____

Past medical history:

Please select any past medical history that applies to you:

- q Arthritis (Osteo / Rheumatoid)
- q Asthma
- q Balance deficits
- q High / low blood pressure
- q Recent weight loss with no reason
- q Cancer
- q Diabetes
- q Headaches / Migraines
- q Heart / Circulation
- q Seizures
- q Psychological ____________________
- q Bone / fractures
- q Allergies: ____________________
- q Drug Allergy / Sensitivity______________

____

Any medical conditions not listed: ____

Any hospitalizations / surgical history:____

Other information: Goals for Therapy ____

Do you have religious or cultural belief(s) that might impact how we deliver your care? No q Yes______________

______________________________ ______________________________

Patient Signature Date Therapist Signature Date / Time

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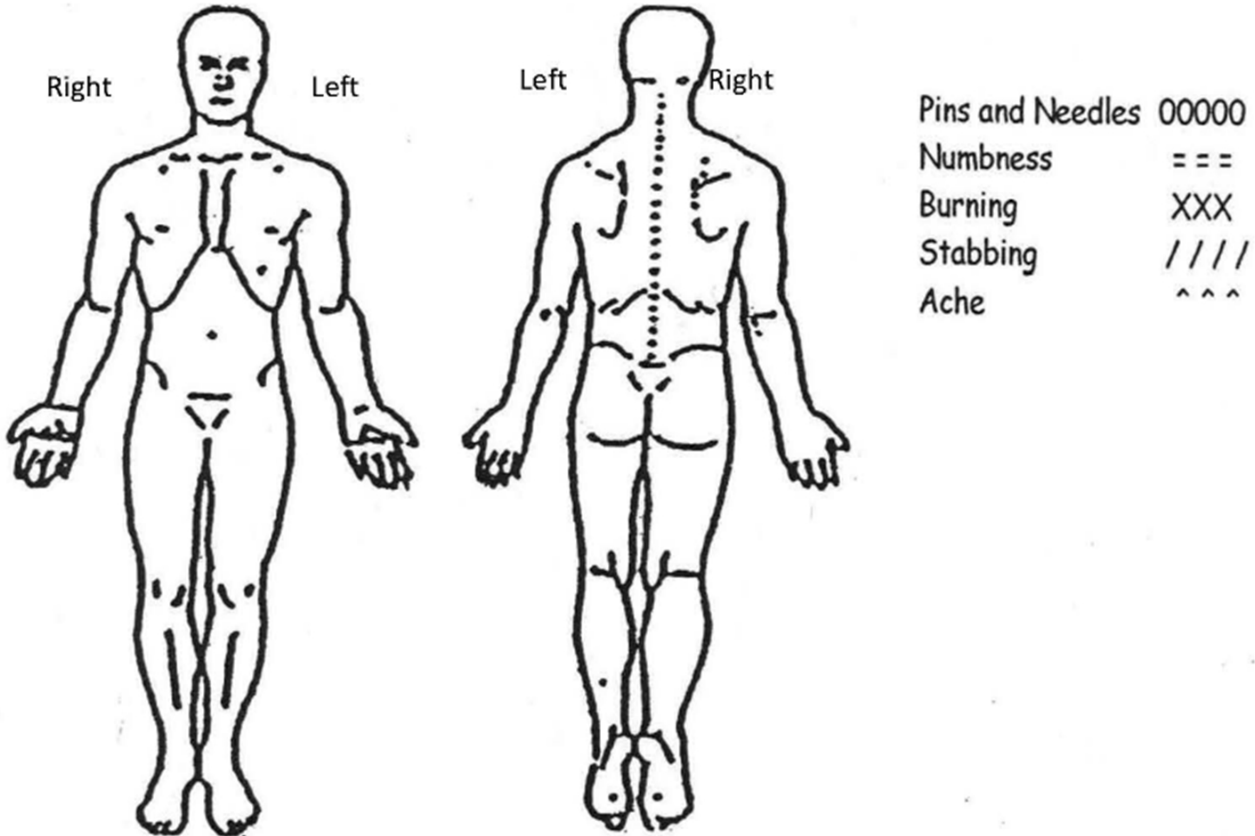
Draw the area of your pain on the diagram below. Use the symbols to show your particular types of pain.



Answer each question below. Circle the number that most describes your level of pain.

0 = No pain. 5 = Moderate amount of pain. 10 = Immediately need to go to the hospital.

Which describes your pain right now?	0	1	2	3	4	5	6	7	8	9	10
Which describes your pain at its best?	0	1	2	3	4	5	6	7	8	9	10
Which describes your pain at its worst?	0	1	2	3	4	5	6	7	8	9	10
Which describes your pain most of the time?	0	1	2	3	4	5	6	7	8	9	10

What is your preferred method of learning? ☐ Demonstration ☐ Verbal Instructions ☐ Written Instructions ☐ Handouts

Patient Signature ____________________ Date

Therapist Signature ____________________ Date / Time