Jordan Valley Medical Center
Physical Therapy Department
Diagnosis Form

Name: ____ Date of Service: _________________________

Referring Physician: _______________________________ Date of Injury/Surgery: _________________

Diagnosis: ____

To Be Completed by the Patient

To help us assess the cause of your problem, we ask you to complete this form before being seen by a physical therapist. Please answer a completely as possible.

Personal Data:

1. Are you currently working? _____ Yes _____ No
2. If yes pleas give your occupation and describe physical demands.
   _____________________________________ ( ) Light ( ) Full duty ( ) Homemaker ( ) Retired
3. What physical activities/sports do you participate in on a regular basis?
   ____
   ____

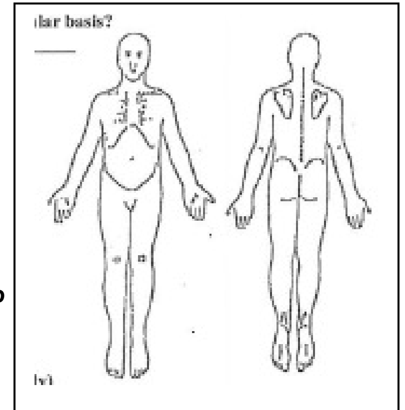
Complaint:

1. What is your main complaint of problem?
   ____
2. Please rate the level of your pain on a scale of 0 to 10.

Worst	0	1	2	3	4	5	6	7	8	9	10
Current	0	1	2	3	4	5	6	7	8	9	10
Best	0	1	2	3	4	5	6	7	8	9	10

   Mild Moderate Extreme Discomfort Pain Agony

3. Please indicate painful areas by shading these models.



4. Which of these words describes your pain? (Check all that apply)
   _____ Sharp _____Dull _____Burning _____Aching _____Numb
   _____ Tingling _____Constant _____ Radiating (moves)
5. List any positions or activities that make your pain worse.
   ____
6. List any positions or activities that lessen your pain.
   ____
7. Are there any barriers that affect your ability to participate in therapy?
   (Check all that apply) ____ Language _____ Culture _____Religion _____ Other
   Explain:
   ____
   ____
8. Are you ready to learn home exercises/activities? _____ Yes _____ No
9. What is your preferred method of learning? _____ Seeing _____ Reading
   _____ Hearing _____ Doing

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History

1. When did your problem start? ______________________________
2. How did your problem start? ______________________________
3. Please list any medications you are taking for this problem.
   ____
   ____
4. What tests or treatment have you had for this problem?
   ____
   ____

Patients Expectations of Treatment

____
____
____

Patients Signature: ______________________________

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