**INITIAL ASSESSMENT FORM**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTH DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WEIGHT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEIGHT: \_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER: \_\_\_\_\_\_\_\_\_\_\_\_\_

SHOES SIZE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY**

LOCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ONSET: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DURATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RADIATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FREQUENCY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INTENSITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHARACTER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AGGRAVATING FACTORS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELIEVING FACTORS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ASSOCIATED SYMPTONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREVIOUS ACCIDENTS/ INJURIES/ SURGERY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREVIOUS MEDICAL HEALTH HISTORY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREVIOUS CHIROPRATIC/MASSAGE/ACCUPUNCTURE/PHYSIOTHERAPY CARE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREVIOUS X-RAYS/MRI/CT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OTHERS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SYSTEM REVIEW:**

CARDIOVASCULAR OTHERS:

HEART: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ VISION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LUNG: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEARING: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HYPERTENSION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GASTROINTESTINAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HYPOTENSION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ URINATION/BOWEL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHOLESTEROL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CANCER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HYPERLIPEMIA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SMOKE/ALCOHOL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STROKE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DIABETES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Working Diagnosis:**

**PAIN DIAGRAM**

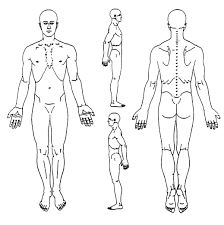
PLEASE MARK THE AREA OF INJURY OR DISCOMFORT ON THE CHART BELOW, USING THE APPROPRIATE SYMBOLS:

NUMBNESS PINS & NEEDLES BURNING ACHING STABBING

………… ο ο ο ο ο ο ∧ ∧ ∧ ∧ χ χ χ χ ⊗ ⊗ ⊗ ⊗

………… ο ο ο ο ο ο ∧ ∧ ∧ ∧ χ χ χ χ ⊗ ⊗ ⊗⊗

………… ο ο ο ο ο ο ∧ ∧ ∧ ∧ χ χ χ χ ⊗ ⊗ ⊗ ⊗



PLEASE USE THE SPACE BELOW TO DESCRIBE YOUR CONDITION FURTHER IF NEEDED:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICAL EXAMINATION**

|  |  |
| --- | --- |
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|  |  |

CERVICAL SPINE LUMBAR SPINE

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **C- SPINE** | LEFT | RIGHT |
| **JASKON** |  |  |
| **SPURLING** |  |  |
| **KEMP** |  |  |
| **SP PERCUSSION** |  |  |
| **FACET RUB** |  |  |
| **DOORBELL** |  |  |
| **VALSALVA** |  |  |
|  |  |  |
| **TRAPEZIUS** |  |  |
| **LEVATOR** |  |  |
| **SCM** |  |  |
| **SCALENE** |  |  |
| **SPLEMINS** |  |  |
| **SUBOCCIPTAL** |  |  |
| **RHOMBOIDS** |  |  |

|  |  |  |
| --- | --- | --- |
| JASKSON | LEFT | RIGHT |
| **KEMP** |  |  |
| **SLR** |  |  |
| **THOMAS** |  |  |
| **FABER** |  |  |
| **SI COMP** |  |  |
| **YEOMAN** |  |  |
| **ELY** |  |  |
| **SP PERCUSSION** |  |  |
| **VALSALVA** |  |  |
|  |  |  |
| **ERECTOR SPINAE** |  |  |
| **QL** |  |  |
| **MULTIFIDI** |  |  |
| **GLUTEALS** |  |  |
| **PIRIFORMIS** |  |  |
| **QUADS** |  |  |
| **HAMSTRINGS** |  |  |

|  |  |  |
| --- | --- | --- |
| **KNEE** | LEFT | RIGHT |
| **VALGUS** |  |  |
| **VARUS** |  |  |
| **JOINT LINE TENDERNESS** |  |  |
| **MCMURRAY** |  |  |
| **ANTERIOR DRAWER** |  |  |
| **POSTERIOR DRAWER** |  |  |
| **LACHMAN** |  |  |
| **SLOCURN** |  |  |
| **PATELLAR COMP** |  |  |
| **NOBLE COMP** |  |  |
| **WILSON** |  |  |
| **CLARK** |  |  |
|  |  |  |
| **ITB** |  |  |
| **QUADS** |  |  |
| **HAMSTRING** |  |  |
| **PSOAS** |  |  |

|  |  |  |
| --- | --- | --- |
| **ETHOW** | **LEFT** | **RIGHT** |
| **VALGUS** |  |  |
| **VARUS** |  |  |
| **COZEN** |  |  |
| **MILLS** |  |  |
| **GOLFER** |  |  |
| **TINELS** |  |  |
|  |  |  |
| **PRONATOR TERES** |  |  |
| **PRONATORIQUAD** |  |  |
| **SUPINATOR** |  |  |
| **EXTTENSOR** |  |  |
| **FLEXOR** |  |  |
| **BICEPS** |  |  |
| **TRICEPS** |  |  |
| **BRACHIORADIALIS** |  |  |

|  |  |  |
| --- | --- | --- |
| **SHOULDER** | LEFT | RIGHT |
| **SPEED** |  |  |
| **YERGASON** |  |  |
| **EMPTY CAN** |  |  |
| **NEER IMPINGEMENT** |  |  |
| **HAWKIN-KENNEDY** |  |  |
| **LIFT OFF** |  |  |
| **DROP ARM** |  |  |
|  |  |  |
| **SUPRASPINATUS** |  |  |
| **INFRASPINATUS** |  |  |
| **TERES MINOR** |  |  |
| **SUBSCAPULARIS** |  |  |
| **DELTOID** |  |  |
| **PECTORAL MAJOR** |  |  |
| **RHOMBOIDS** |  |  |
| **LATISSIMUS** |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| NEURO | REFLEXES | MOTER | SENSORY |
|  | L R | L R | L R |
| C5 |  |  |  |
| C6 |  |  |  |
| C7 |  |  |  |
| C8 |  |  |  |
| T1 |  |  |  |
| L4 |  |  |  |
| L5 |  |  |  |
| S1 |  |  |  |

**Diagnosis:**