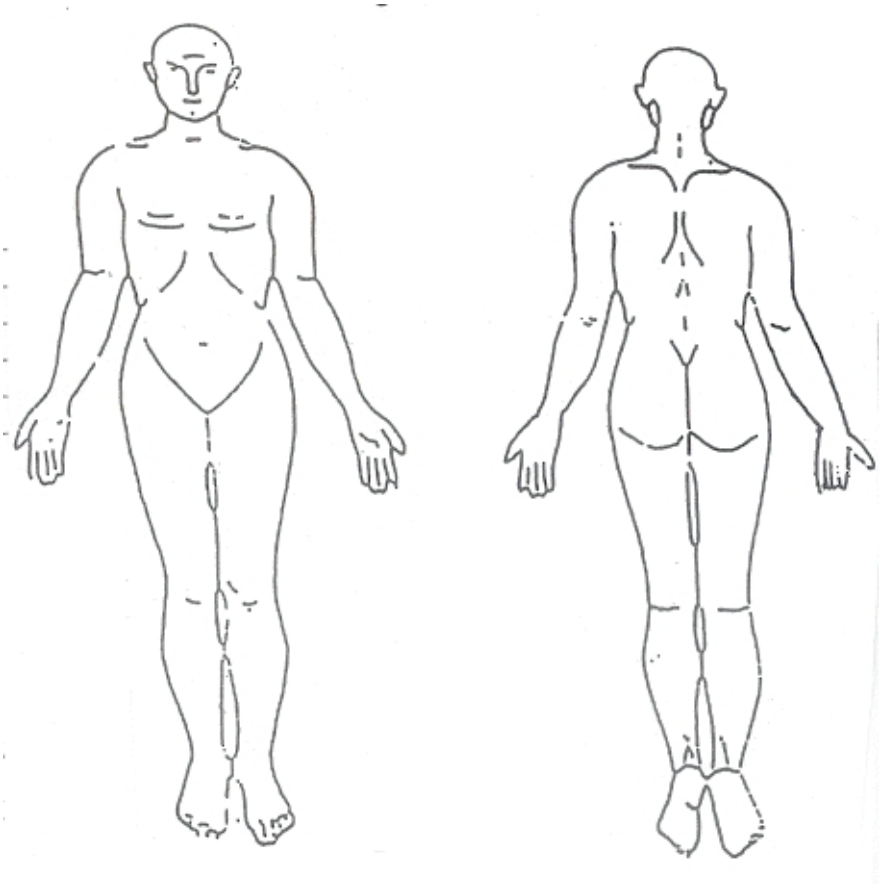
Patient Name: **Today's date:**

Please read this form over and then fill out those questions which are relevant and feel comfortable. Imagine this as a bridge between you and me. With some extra insight into your experience, some descriptive adjectives for your sensations, we can create something that will be yours' to use for your continued healing and growth.

Step One: On the body chart below, place the most appropriate symbol where your pain or discomfort occurs. Use:

- /// for sharp pain
- ooo for dull pain
- xxx for burning or radiating pain
- = = = for numbness
- * +++ for swelling
- * <> for joint noise
- * <<< for weakness
- * ^^^ for tightness

Step Two: Using a 0-10 scale, give each place you mark on the body, a range, like 0-3, or 3-7 showing the worst and the best in average days.



Sherry Brourman Physical Therapy and Yoga Therapy Clinic Evaluation

Name:	Age and Date of Birth:
Email:	Mobile Phone:
Home Phone:	Work Phone:
Street Address:	City and State:
Name of current Doctor(s)	
Emergency Contact:	Emergency Contact phone:
Your Occupation?	Referred by:
Do you enjoy your work?	Most common position at work, ie sitting and average hours/day?
Reason(s) for visit?	Date of onset of discomfort or pain:
History timeline: if you can create a timeline on the back with date markers and brief descriptions: <----------> this helps tremendously. If not, a note here to the right will work too.	History:
Do you exercise presently? (Y/N) How? Do you have a favorite?	What may have precipitated this injury or pain?
Do you practice yoga (Y/N), # of years? Are there postures that aggravate your discomfort?	Are you comfortable with your posture, movement, walking? Please name a few things that seem to bother.
For pain, what are you inclined to do?	Do you go to sleep in pain? (Y/N) Do you awaken in pain? (Y/N) Is sleep interrupted by pain? (Y/N)
Average hours of sleep per day?	Average hours of work per day?
What would you like to see happen in your therapy?	Specifically, and short term? Globally and long term?
Biggest concern around this?	Physically, what would you love to do?
If there are activities that you opt out of due to pain, discomfort or even fear, mention a few.	Any other restrictions due to pain?

What is your average stress level on a scale from 1 to 10 with small and manageable being 1 and nerve-wracking being 10.	Description of stress:
Do you notice if your breathing changes with pain or with stress?	Are you comfortable with your energy level?
What is your favorite part of your life? Include hobbies.	What is your least favorite part of your life? Include any habits you would like to shift.
In your young life, how was your physical pain perceived, treated and managed?	How was stress managed in your birth family?
How are your present relatives or close circle of friends, about your pain?	Do you tend to keep it private, to be brave, or, do you find it comforting to discuss with them?
What are your favorite forms of relaxation?	Do you have a spiritual practice, not necessarily formal, and could be any daily rituals or ways of quieting so that you can hear yourself?
Is there anything else in your medical history that would be helpful for us to discuss or for me to know?	Is there any history of cancer, heart or lung disease for you or in your family?

This therapy practice is about giving you the tools, to be your own therapist. Please discuss any questions or notions you have to enhance our co-creation of your healing process. I am honored to work with you, to be a gentle guide along your path and to help you to connect to your strength.

Please check and give a date and description to any of the following:

Date Description
_____ RheumatoidArthritis_____

_____ Osteoporosis_____
_____ Bone fractures_____
_____ Dizziness, vertigo or balance difficulty_____
_____ Joint Swelling_____
_____ Neurological disorder_____
_____ Disc issues or pinched nerve_____
_____ Arm or leg pain due to nerves_____
_____ Joint dislocation_____
_____ Traumatic accidents_____
_____ Traumatic illnesses_____
_____ Major surgeries_____
_____ Cardiac/Heart Illness/Issues_____
_____ Breathing/Respiratory Illness/Issues_____
_____ Headaches_____
_____ Cancer_____
_____ Menopausal challenges_____
_____Depression_____
_____Anxiety_____
_____Other_____

This last section is for you and us to consider if or how your lifestyle and priorities may have shifted or are shifting in response to your awareness of discomfort. If it feels irrelevant, you're welcome to skip it.

And lastly, *at of the time of your pain incident or last resurgence*, can you please place the following in order of their most to least important: (it's ok if a few are 1's or any number repeats.

Family & Friends__, Career__, Money__, Health__, Heart/Relationship__, Fun & Recreation__, Personal Growth__, Physical Environment (at home)__

And repeat the exercise please for now/current timeframe:

Family & Friends__, Career__, Money__, Health__, Heart/Relationship__, Fun & Recreation__, Personal Growth__, Physical Environment (at home)__