Medical Evaluation Form

Medical Evaluation Form

ARTHRITIS & SPORTS

Orthopaedics • Physical Therapy • Wellness

Patient Name: _____ **Date:** _____

Check all that apply (these may prevent treatments in certain locations):

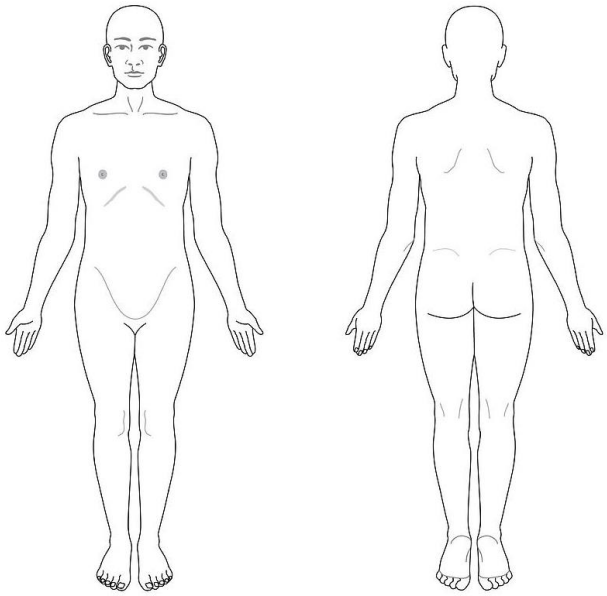
- ☐ Bleeding/clotting disorder
- ☐ HIV positive history
- ☐ Leukemia
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Presence/history of cancerous lesion(s)
- ☐ Seizure disorder triggered by light
- ☐ Spinal cord stimulator
- ☐ Steroid injection within past 2-3 weeks

Diagnosis:

- ☐ Achilles Tendinitis
- ☐ Acute Pain 5 – 10
- ☐ Ankle
- ☐ Arthritis – anywhere
- ☐ Backache
- ☐ Chronic Pain 1 – 4
- ☐ Contusion
- ☐ Dislocation
- ☐ Extreme Pain CPW
- ☐ Fracture
- ☐ Heel Pain
- ☐ Hematoma
- ☐ Hip Pain
- ☐ Inflammation Only
- ☐ Knee Pain
- ☐ Lumbar Pain
- ☐ Muscular Strain
- ☐ Muscular Tear
- ☐ Neck Pain
- ☐ Neuroma
- ☐ Neuropathy
- ☐ Plantar Fasciitis
- ☐ Post-Op Pain
- ☐ Sciatic Pain
- ☐ Shoulder Pain
- ☐ Strains or Sprains
- ☐ Tendinitis – General
- ☐ Tennis Elbow
- ☐ Vertigo
- ☐ Wounds - Scars

Treatment Area

circle the area to be treated (one area per sheet)



Provider Signature: _____ Date: _____

Provider Name (please print): _____

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