PHYSIO WELLNESS
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TLOUBATLA ME INC
Bsc.Physio (MEDUNSA)

Pr. Number: 0479713

Reg No: 2012/180371/21
VAT No: 4280276090

Health Emporium
197 Market Street Midrand, 1682

DNA Consulting Suites
129 Rivonia Road Sandton, 2196

011 805 1433

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PHYSIOTHERAPY INITIAL EVALUATION FORM

Name & Surname: _____ **File No:**_____

1. Referral Information

Referred by:	◯Doctor ◯Specialist ◯Self ☐ Other:_____

2. Presenting Complaint

Main Complaint:	
Onset Date:	____/____/____
Duration of Symptoms:	◯ Days ◯ Weeks ◯ Months ◯ Years
Mechanism of Injury / Cause:	
Previous Episodes of Similar Problem:	◯ Yes ◯ No – If yes, when and how often?
Pain Level (0 = None, 10 = Worst):	0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10
Pain Pattern / Timing:	◯ Morning stiffness ◯ Worse at night ◯ Pain with activity ◯ Pain at rest
Pain Description:	◯ Sharp ◯ Dull ◯ Aching ◯ Burning ◯ Radiating ◯ Throbbing ◯ Numbness/Tingling ◯ Other:

Pain Location / Area Affected:	
Pain Radiation	
Frequency:	◯ Constant ◯ Intermittent ◯ Occasional
Duration of Pain	
Aggravating Factors	(e.g., walking, standing, bending, lifting, sitting long periods, stairs):
Relieving Factors:	(e.g., rest, heat/ice, medication, position changes, activity):
Impact on Daily Activities	(e.g., difficulty dressing, bathing, working, driving, exercising):
Sleep Disturbance due to Pain	◯ Yes ◯ No – If yes, describe:
Other Associated Symptoms	◯ Swelling ◯ Weakness ◯ Stiffness ◯ Locking ◯ Instability ◯ Headaches ◯ Other:

3. Medical History

	Yes / No	**If Yes, please specify**
Previous Injuries or Surgeries	◯ Yes ◯ No	
Chronic Conditions (e.g., diabetes, hypertension)	◯ Yes ◯ No	
Medications	◯ Yes ◯ No	
Allergies	◯ Yes ◯ No	
Radiology (X-Ray, Ultrasound, MRI)	◯ Yes ◯ No	
Other Relevant History	◯ Yes ◯ No	

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4. Functional Status & Lifestyle

Occupation	
Work Status	◯ Full Duty ◯ Light Duty ◯ Off Work
Sports / Hobbies	
Activities Affected	
Mobility Aids (if any)	◯ None ◯ Cane ◯ Crutches ◯ Walker ◯ Wheelchair

Other Relevant Details: Please provide any additional information that may assist your physiotherapist in understanding your condition and planning your treatment:

Physiotherapist Signature: _____ **Date:** ____ / ____ / _____