

Client Assessment

Clinic: _____ **Treating Therapist:** _____

To be completed by Patient	
Client Name:	First Treatment Date:
Client Reference number:	Date of Birth:
Address:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Suburb:	P/Code:
Phone (Home):	Occupation:
Phone (Work):	Referral: Yes <input type="checkbox"/> No <input type="checkbox"/> By:
Phone (Mob):	Health Fund:
E-mail:	Workers Comp:

- Do you have, or have you ever suffered with any of the following: (Please tick)

<input type="checkbox"/> High/low blood pressure	<input type="checkbox"/> Hernia	<input type="checkbox"/> Thrombosis
<input type="checkbox"/> Heart condition	<input type="checkbox"/> Tumours, cysts	<input type="checkbox"/> Skin diseases / disorders
<input type="checkbox"/> Varicose veins/phlebitis	<input type="checkbox"/> Kidney infection	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Injury / Operation	<input type="checkbox"/> Haemorrhage	<input type="checkbox"/> Asthma
<input type="checkbox"/> Slipped disc / Back condition	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Abdominal / chest complaint
<input type="checkbox"/> Rheumatoid/osteo arthritis	<input type="checkbox"/> Other Conditions?	

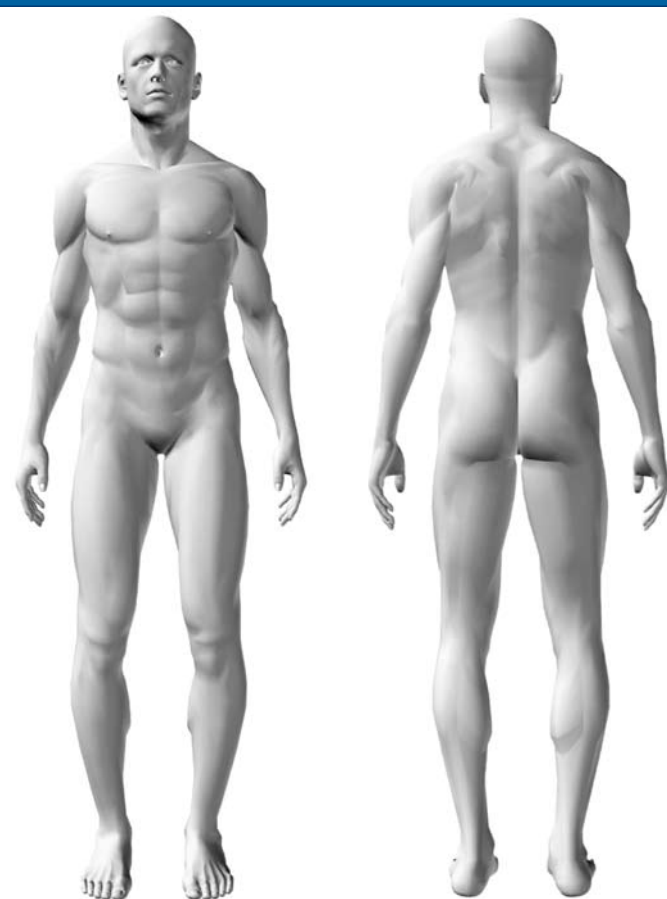
- Female Clients – is it possible you may be pregnant? Yes No

- Medication – please list current medications, if any: _____

To be completed by Therapist

- History of Complaint:

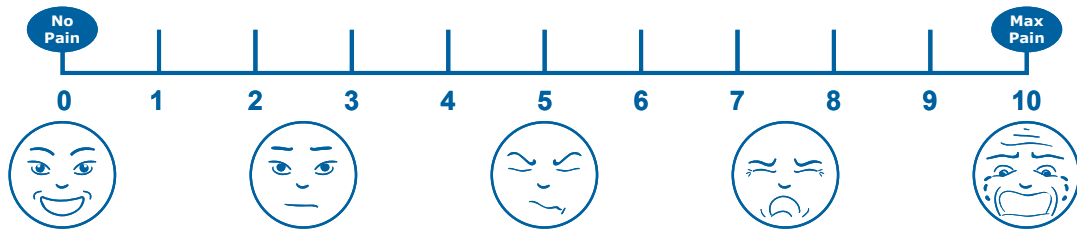
- Presenting Complaint now:



- (Please localise the complaint: is it top / bottom - front / back - left / right ?)

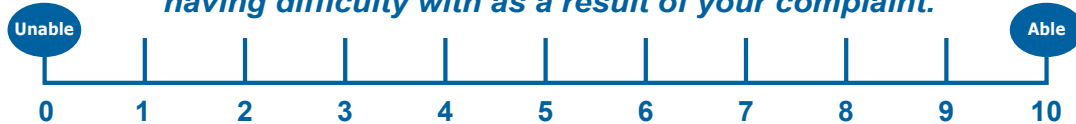
PAIN Assessment - Visual Analog Scale

Please identify your current level of pain using the scale below (please circle ○)



FUNCTIONAL Assessment - Patient Specific Scale

Please identify up to three (3) important activities that you are unable to do or are having difficulty with as a result of your complaint.



Activity 1.	Score 1.
Activity 2.	Score 2
Activity 3.	Score 3

Date: _____ Complaint/Treatment: _____	Pain Score Today	Before Treatment	After Treatment	
	Activity 1 Score	Before Treatment	After Treatment	
	Activity 2 Score	Before Treatment	After Treatment	
	Activity 3 Score	Before Treatment	After Treatment	

Date: _____ Complaint/Treatment: _____	Pain Score Today	Before Treatment	After Treatment	
	Activity 1 Score	Before Treatment	After Treatment	
	Activity 2 Score	Before Treatment	After Treatment	
	Activity 3 Score	Before Treatment	After Treatment	

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Date: _____ Complaint/Treatment: _____	Pain Score Today	Before Treatment	After Treatment	
	Activity 1 Score	Before Treatment	After Treatment	
	Activity 2 Score	Before Treatment	After Treatment	
	Activity 3 Score	Before Treatment	After Treatment	