# Current Assessment

Date: ______________________

DunbarPhysio

**Name**: ______________________________________________ **DOB:** _______________________

**Email:** _________________________________________________ **Family Dr.** ________________________________________

**Occupation**: ____________________________________________ **Hobbies**:___________________________________________

☐ **Injured at work**

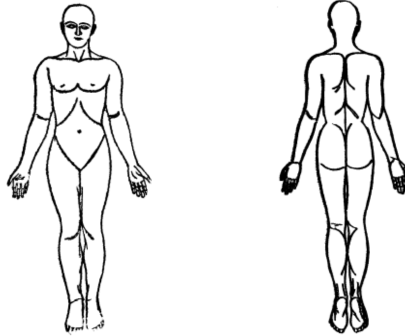
☐ **Injured in Motor Vehicle Accident**

**Complaints & Symptoms:**
List below and mark on chart

___________________________________

___________________________________

___________________________________



**Other Symptoms**

☐ Headaches
☐ Vertigo/Dizziness/Light-head
☐ Pins and Needles/Numbness
☐ Bowel and/or bladder changes
☐ Nausea
☐ General Malaise
☐ Sleep Disturbance
☐ Recent unexplained weight change
☐ Double Vision/Eye Issues
☐ Loss of consciousness
☐ Difficulty Speaking
☐ Difficulty Swallowing

**Medication**: ☐ Steroids (past/present) ☐ Blood Thinners ☐ ___________________ ☐ ____________________

☐ ___________________ ☐ ___________________ ☐ ___________________ ☐ ____________________

**Investigations** – for this problem & date

☐ X-Ray ☐ CT Scan ☐ Other
☐ MRI ☐ US Scan

**Pain**: ☐ Improving ☐ Same ☐ Worsening

☐ Constant ☐ Intermittent

**Activities/movements that worsen your pain**: ____________________________________________________________

**Activities/movements that improve your pain**: ___________________________________________________________

**Pain Scale:** No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

**Medical History**

☐ Cancer (past or present)
☐ Radiation Therapy (last 6 months)
☐ Chemotherapy (last 6 months)
☐ Cardiac Pacemaker
☐ Heart Issues (past or present)
☐ Osteo/Rheumatoid Arthritis
☐ Osteoporosis
☐ Diabetes
☐ Surgeries
☐ Broken Bones
☐ Pregnant (or trying)
☐ Family History of Disease
________________________________
☐ Other
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