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ARPwave Initial Evaluation Form

Contraindications-History of **Blood clots, pacemakers, defibulators, or pregnancy**-(circle)
Note: If client answers **YES** to any of the above questions, they are not a candidate.

Patient Name:_____Evaluation date:_____

Therapist Name:_____

Primary Medical Physician:_____Phone_____

Previous diagnostic tests/ Results(MRI, X-Rays, Labs, etc.)_____

On a scale of 1-10, the worst being 10. What level of pain do you have when doing a movement or activity that bothers you?

PAIN LEVEL:_____Feels like (burning, tingling, sharp, stabbing):_____

If you were to prioritize your symptoms- which are keeping you from having an active quality of life, please tell me what is the number one thing that bothers you the most?

Priority #1 Pain:_____ How long have you had this pain:_____
Priority #1 Other symptoms:_____ How long:_____

When did you first have symptoms:_____
What happened to cause symptoms:_____
What have you done to relieve symptoms:_____
What other therapies have you tried: _____
(Massage, medication, PT, Surgery, Chiropractic, etc.)
Have you had Surgery for your symptoms:_____
Have you been told you need surgery for your symptoms:_____
Are you taking medication for your symptoms:_____
Movement that bothers you most:_____
What activity have you stopped due to pain:_____
When was the last time you did the activity without pain:_____
Is there a priority #2:_____ Priority #3_____

Anyone in your family diagnosed with: MS, RSDS (Reflex Sympathetic Dystrophy Syndrome)- also known as complex regional pain syndrome, is a rare disorder of the sympathetic nervous system that is characterized by chronic, severe pain., Fibromyalgia, POTS (Postural Orthostatic Tachycardia Syndrome (Elevated HR upon standing 120+BPM), Spinal cord Injury, Concussion, Or stroke. (Circle all that apply)