

Personal Best Performance Evaluation

Date: _____

Name: _____ Age: _____

Referring MD: _____ Diagnosis: _____

What brings you to therapy today?: _____

What was your date of injury or when and how did this problem begin?:

Have you had any special tests?: _____

What are your goals for participating in this program?: _____

Please describe any past or present orthopedic problems:

Feet _____

Ankle _____

Knee _____

Thigh _____

Groin _____

Hip _____

Back _____

Ribs _____

Neck _____

Shoulders _____

Arms _____

Other _____

Please describe any past rehabilitation for the above injuries: _____

Other: _____