Client Assessment

SCENAR Therapy System

Clinic:_____ **Treating Therapist:** _____

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

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

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

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

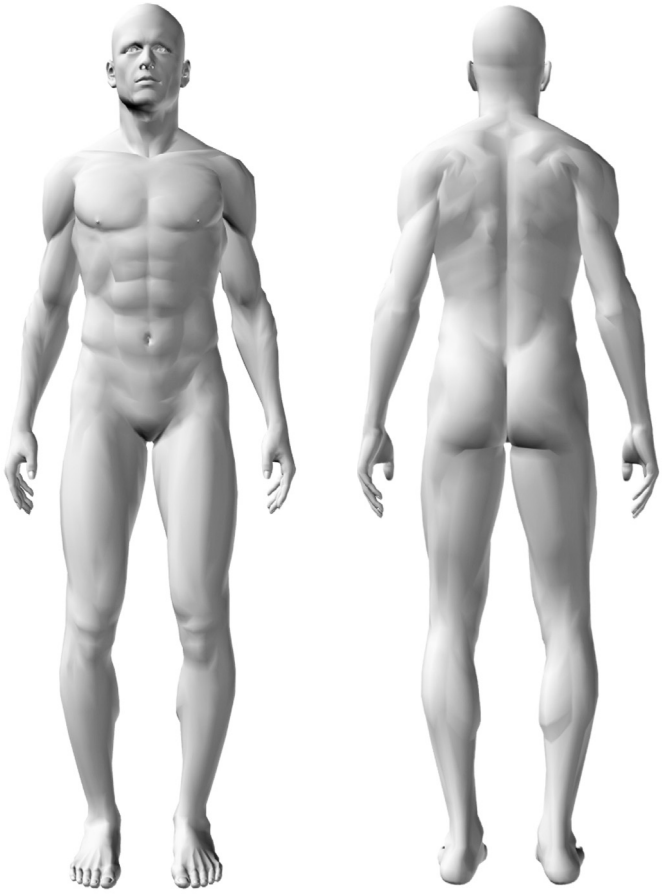
- Medication – please list current medications, if any: _____

_____

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 ◯)

No Pain — 0 1 2 3 4 5 6 7 8 9 10 — Max Pain

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.

Unable — 0 1 2 3 4 5 6 7 8 9 10 — Able

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	
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