Office Use Only

MEDICAL HISTORY AND SUBJECTIVE INFORMATION FORM

Please answer the following questions as completely as possible. **Please** use **black ink only**, and **do not fill in shaded areas.** Shaded areas are for **OFFICE USE ONLY**. If you need help filling out this form, we would be happy to assist you.

Name: ____ **Birth Date:** ________________ **Today's Date:** ________________

*Date of injury/problem:	*Date you went to your doctor for help with this injury/problem:
*Briefly describe how your problem occurred. (Include dates if possible.)	
Therapist Comments	
When are you scheduled to return to your doctor? ☐ Not Scheduled ☐ ________________	
*What would you like to accomplish in therapy (what are your goals)?	

Rate your pain on a scale from 0-10 (0=no pain, 10=worst pain): *Current____ *Best____ *Worst____

Describe your pain: ☐Constant ☐Intermittent ☐Sharp/Stabbing ☐Dull /Aching ☐Burning ☐Throbbing ☐Other:

What makes your Pain/Symptoms…

*Better (or decreases your pain):____

*Worse (or increases your pain):____

When are your symptoms better: ☐AM ☐PM ☐Other:____________________

When are your symptoms worse: ☐AM ☐PM ☐Other:____________________

Does your pain wake you? ☐No ☐Yes: ____________________________

Do you sleep through the night? ☐No ☐Yes: ____________________________

*Do you have numbness? ☐No ☐Yes, location: ____________________________

*Do you have tingling? ☐No ☐Yes, location: ____________________________

Therapist Comments

***Please shade in the painful areas below:**

Front **Back**

R L L R

***PREVIOUS TREATMENT (S)** for this condition (please check all that apply): ☐**None**

Health Care Provider	Name / Date	Health Care Provider	Name / Date
☐ Family Doctor		☐ Physical Therapist	
☐ Specialist		☐ Occupational Therapist	
☐ Psychiatrist/Psychologist		☐ Speech Therapist	
☐ Pain Clinic		☐ Chiropractor	

Therapist Comments: ☐ Prior treatment reviewed

***DIAGNOSTIC TEST (S): Have you had any of the following for your current condition? (If yes, please check and state results.)**

Test	Date / Result	Test	Date / Result
☐ None		☐ MRI	
☐ X-rays		☐ EMG	
☐CT scan		☐ Other	

Therapist Comments: ☐ Prior tests reviewed.

Office Use Only

***MEDICAL HISTORY:**

***Any past surgeries**? ☐No ☐Yes, please list and date:

(Please check each box that applies) ☐ **Reviewed with patient (Unremarkable)**

Have you had any of the following:

Is there any chance you may be pregnant? ☐No ☐Yes, _____# of months

☐Heart disease/attack ☐Lung disease/asthma ☐Stroke ☐Arthritis (type: ___________)
☐Pacemaker/defibrillator ☐Kidney disease ☐Head injury ☐Osteoporosis/osteopenia
☐High blood pressure ☐Liver disorder/hepatitis: _____ ☐Headaches ☐Metal implants
☐Circulation problems ☐Thyroid disease ☐Seizures ☐Stomach disorders
☐Diabetes (type: ___________) ☐Skin disease ☐Dizziness ☐Frequent nausea/vomiting
☐Blood issues/history of clot ☐Cancer (type: _____________) ☐Swallowing problems ☐Bowel/bladder issues
☐HIV (+) ☐MRSA/VRE(+) ☐Mental health issues ☐Neuromuscular disease
☐ Shingles (current / history of)

☐**Other medical history that we need to be aware of, i.e., accidents or other?** ____

____

Hearing loss: ☐No ☐Yes **Hearing aids**: ☐No ☐Yes **Glasses/Contact lens**: ☐No ☐Yes

Allergies to: ☐None ☐ Tape/Latex ☐Adhesive ☐Environmental ☐ Drug Type__________________________

Do you smoke? ☐No ☐Yes, how many packs/day:_____ **Do you drink alcohol?** ☐No ☐Yes, how much: _______________

***List all current medications including over-the-counter types *(If you have a list, we will photocopy it.)*:** ☐ **None**

____

____

Therapist Comments:

***EMPLOYMENT:**

Are you currently working? ☐Full-time ☐Part-time ☐Retired ☐Disabled ☐Student ☐Unemployed

Occupation / Job Title / Responsibilities: ____

List any restrictions:____

What problems are you having at work due to your condition: ____________________________

____

List any hobbies: ____

Therapist Comments: (Return to work goals: Industrial Rehab, disability, restrictions, lifestyle, hobbies, home life.)

PERSONAL INFORMATION/ACTIVITIES OF DAILY LIVING:

Home: ☐1-story with/without basement ☐2-story home with/without basement
☐Apartment with/without elevator ☐Mobile Home
☐Other: ____

Stairs: Maximum # of stairs in your home:_____

When going up the stairs, are handrails on the:
☐Left ☐Right ☐Both ☐None

Lives (with): ☐Spouse ☐Alone ☐Family ☐Friend(s) ☐Other ______________________________________

Therapist Comments:

Equipment: Equipment used at home (lift chair, bathroom rails, etc): ☐ None ☐Yes, equipment used:______________________

Prior to this, did you walk using a device? ☐No ☐Cane ☐Crutches ☐Standard Walker ☐Rolling Walker ☐Other: ____________

Falls: Number of falls you have had in the last month/year? ☐ None ☐Yes (If yes, number of falls last month:_____/ last year:_____)

What is your primary language? ☐ English ☐ Other ______________________________________

Needs: Do you have any additional needs? ☐No ☐Yes (If yes, check all that apply) ☐Large Print ☐Nutrition Counsel
☐Interpreter for ______________language ☐Cultural/Religious ☐Counseling ☐Support Groups ☐Other: _________________

Office Use Only

Please review the list below and rate those tasks that your condition affects using the scoring guide below.

Only rate those tasks that apply to you.

SCORING GUIDE

0=Able to perform at the same level as before injury or problem   0 1 2 3 4 5 6 7 8 9 10   **10**=Unable to perform activity

Please circle your responses below

TASKS	RATING (0-10)	THERAPIST COMMENTS
Sitting		
Standing		
Walking		
Running		
Stairs		
Balancing		
Kneeling		
Bending / Stooping		
Jumping / Hopping		
Sleeping		
Positional changes in bed		
Getting in/out of bed, chairs, car, etc.		
Driving including fastening seatbelt		
Housekeeping		
Yard work		
Job responsibilities including computer work		
Leisure tasks		
Pulling / Pushing / Reaching		
Lifting / Carrying		
Personal care (grooming, bathing, dressing, toileting, etc.)		
Gripping / Grasping		
Coordination (upper or lower body)		
Eating / Swallowing		
Speaking		
Understanding Speech		
Writing		
Reading		
Other:		
Other:		

ADDITIONAL COMMENTS: History reviewed with patient: ☐Yes ☐No

Patient's signature/date:	*Therapist(s) signature/date/time: