MEDICAL HISTORY/SUBJECTIVE INFORMATION

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Your Name:				**Today's Date:**
Date of Birth:	**Age:**	**Height:**	**Weight:**	**Do You Smoke? Yes No**
Sex: Male Female If female, are you currently pregnant? **No Yes If yes,** 1st Trimester 2nd Trimester 3rd Trimester				

Have you ever been diagnosed with any of the following?

Tuberculosis	No	Yes	Cancer	No	Yes	Arthritis	No	Yes
Diabetes	No	Yes	Hepatitis	No	Yes	Stroke	No	Yes
Heart Condition	No	Yes	Epilepsy	No	Yes	Respiratory Problems	No	Yes

Other:____

Who referred you to physical therapy? ______________________________

Primary Physician ____________________________________

Tell Us About Your Condition

When did you first notice the pain or have functional problems due to the condition/injury? (Please provide approximate dates): ______________________________

Recent flare-up? No Yes If yes, when ______________________________

What activities are limited by this condition? (e.g. lift, reach):________________________

How did your injury/symptoms occur? ______________________________

____

What do you expect to accomplish with physical therapy? ________________________

Are your symptoms: Constant? Intermittent? Getting Better?

Getting worse? Staying the same?

What makes your symptoms better? ______________________________

0-10 pain scale (0 = No Pain; 5= Moderate Pain; 10 = The Most Extreme Pain)

Worst pain rating: 0 1 2 3 4 5 6 7 8 9 10

Best pain rating: 0 1 2 3 4 5 6 7 8 9 10

For this injury, has your medical care included: (check those that apply)

Surgery: When? ___/___/___ What kind?______________________________

Injection: When? ___/___/___ Did it help? Yes No

Other treatment:

Physical therapy If yes, when? ___/___/___to ___/___/__

What was done?____

Chiropractor If yes, when? ___/___/___to ___/___/___

What was done? ____

Medications: ____

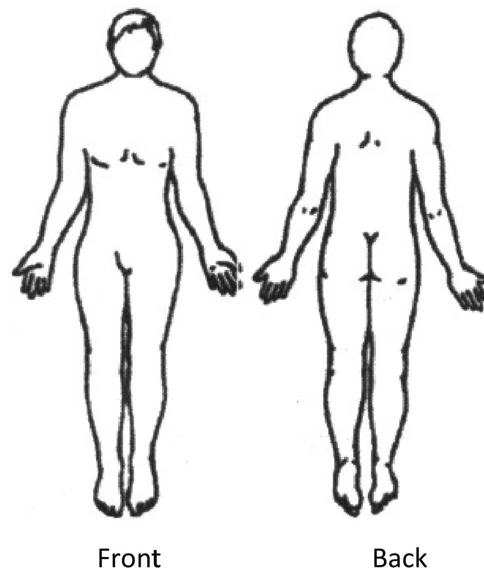
X-ray ________________________ MRI ________________

CT scan ________________________ Other: ____________________

Exercises: What kind? ____

Indicate on body diagrams **where** your symptoms are located

= Pain ***III*** = Numbness



Comments:____

Work Information

Who is your employer? ____

What is your job title/responsibilities? ____

Are you currently working? No Yes If yes, numbers of hours per week ________________________________

Full Duty Restricted Duty

How many total work days have you missed? ______ Do you have a case manager/QRC? No Yes

Your Therapist Will Complete This Section

Critical work, ADL, or leisure activities affected: ____

- Lift/carry: ≤20 lbs. rarely to occasionally (**low demand**)
  > 20 lbs., or > 1lb. constantly or > 10 lb. frequently (**mod-high demand**)

  Where to where _________________ to ___________________.

- Repetitive motions related to condition: Occasional 1-33% (**low demand**)
  Frequent to Constant 34-100% (**mod-high demand**)

- Static positions related to condition (**mod-high**): Sit Stand Crouch
  Kneel Overhead work ____________________

- Leisure Activities: None/minimally impact condition **(low demand)**
  Moderate-high intensity, competitive **(mod-high demand)**

Overall functional demand (work/ADL/leisure) Low Demand Moderate-High Demand

Comments: ____

Additional Comments:____

Indicate either "Yes" or " No" as to whether each of the following activities is difficult.

Activity		Activity	
Drinking or Eating	_Yes _No	Balancing on both feet	_Yes _No
Sleeping Through the Night	_Yes _No	Walking on: stairs, flat surfaces, inclines, uneven surfaces, ladders	_Yes _No
Dressing: Putting on or taking off shoes, socks, shirt, jacket or pants	_Yes _No	Lifting	_Yes _No
Maintaining static position of; Head bent forward, arms overhead, arms forward, or turning head	_Yes _No	Carrying	_Yes _No
Getting in/out of: chairs, bed, car or bath/shower	_Yes _No	Bending, Kneeling Squatting	_Yes _No
Reaching: overhead, behind back, downward for forward	_Yes _No	Driving a vehicle or ability to use gas/brake pedals	_Yes _No
Gripping, Holding tools or Opening Jars	_Yes _No	Caring for child or adult	_Yes _No
Picking up Small Objects	_Yes _No	Housework / Yard work	_Yes _No
Sitting	_Yes _No	Recreational Activities	_Yes _No
Standing	_Yes _No	Have you fallen more than 1 time in the past year	_Yes _No
Job Related Activities	_Yes _No	Have you fallen and hurt yourself in the past year	_Yes _No

Other: