



**MEDICAL HISTORY / SUBJECTIVE INFORMATION**

Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

**Medical History: (Please check all that apply)**

- |  |                                       |  |                                     |
|--|---------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker  |
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Visual Impaired     | <input type="checkbox"/> Epilepsy   |
| <input type="checkbox"/> HIV/AIDS      | <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Hearing Impaired    |                                     |
| <input type="checkbox"/> Stroke        | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Latex Allergy       | <input type="checkbox"/> Scoliosis  |
| <input type="checkbox"/> Osteoporosis  | <input type="checkbox"/> Hepatitis    | <input type="checkbox"/> Pregnant            | <input type="checkbox"/> Depression |

Other \_\_\_\_\_  
 Therapist's comments: \_\_\_\_\_

Have you had surgery for your condition? Y N Date: \_\_\_\_\_  
 Have you had any injections for your condition? Y N Date: \_\_\_\_\_  
 Please list any diagnostic tests you have had for this condition: \_\_\_\_\_

Please list any **medications** that you are taking: \_\_\_\_\_

**How** did the injury or problem occur? \_\_\_\_\_  
 \_\_\_\_\_

**When** did the injury or symptoms occur?  
 First episode: \_\_\_\_\_ Second episode: \_\_\_\_\_ Third episode: \_\_\_\_\_

**What** are your current symptoms? \_\_\_\_\_

**Please rate your pain using a 0 – 10 scale** (0 = no pain, 10 = the worst pain you can imagine)  
**Worst** pain since onset: \_\_\_\_\_ **Best** pain since onset: \_\_\_\_\_ **Today's** pain: \_\_\_\_\_  
**Where** is your pain or problem located? \_\_\_\_\_

Is your pain? **Constant** **Intermittent**

What makes your pain / problem **better**? \_\_\_\_\_ **Worse**? \_\_\_\_\_

Is there pain present at night? Y N What position helps you to sleep? \_\_\_\_\_

Therapist's Comments: \_\_\_\_\_  
 \_\_\_\_\_

**Employment History:**

Are you currently working? Y N  
 How many total days of work have you missed? \_\_\_\_\_  
 Are your work duties? Full Restricted How many hours per week do you work? \_\_\_\_\_  
 Who is your employer? \_\_\_\_\_  
 What type of work do you do? \_\_\_\_\_  
 What critical work duties have been most affected by your problem? \_\_\_\_\_  
**What do you hope to accomplish with therapy?** \_\_\_\_\_

Please complete the following page



**PLEASE RATE YOUR ABILITIES USING THE FOLLOWING SCALE:**

1 = CAN DO WITHOUT DIFFICULTY  
 2 = CAN DO WITH SOME DIFFICULTY

3 = CAN DO WITH GREAT DIFFICULTY  
 4 = CAN'T DO AT ALL

	1	2	3	4	Comments: <b>Therapist use only</b>
Lying down	1	2	3	4	_____
Sitting	1	2	3	4	_____
Standing	1	2	3	4	_____
Walking	1	2	3	4	_____
Jogging/running	1	2	3	4	_____
Going up stairs	1	2	3	4	_____
Going down stairs	1	2	3	4	_____
Lifting/carrying	1	2	3	4	_____
Driving a car	1	2	3	4	_____
Overhead reaching	1	2	3	4	_____
Housework	1	2	3	4	_____
Yardwork	1	2	3	4	_____
Dressing	1	2	3	4	_____
Sexual activity	1	2	3	4	_____
Are you exercising at home?			Y	N	If yes, what type? _____

Are you using heat or cold? \_\_\_\_\_

Are you wearing a sling or brace?            Y     N     If yes, what type? \_\_\_\_\_

Do you smoke?                                    Y     N     If yes, how much? \_\_\_\_\_

What type of non-work activities are you involved in? \_\_\_\_\_

**When** are you scheduled to see your doctor again? \_\_\_\_\_ .

Therapist's comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Therapist Signature: \_\_\_\_\_

**To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services at Premier Physical Therapy.**

Patient Signature: \_\_\_\_\_

