

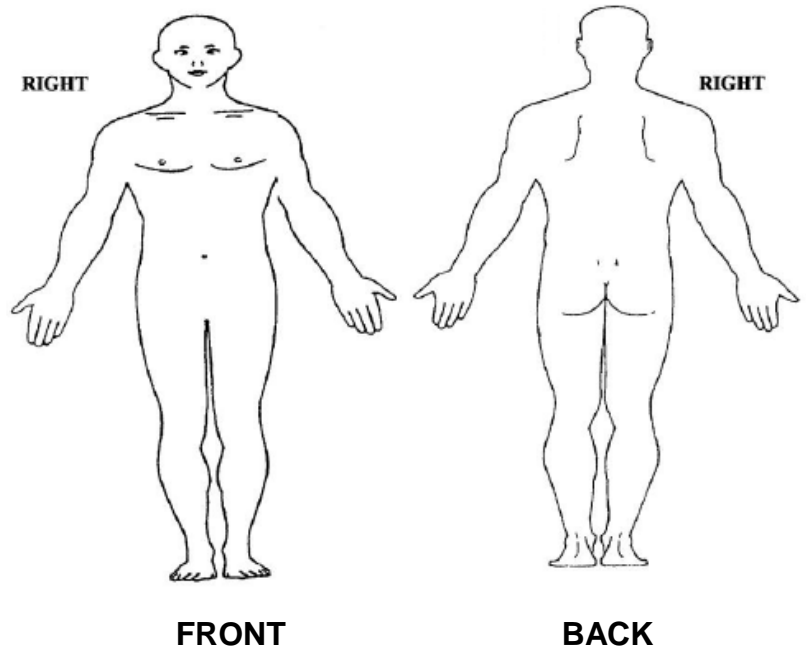
Patient: _____ DOB: _____

Today's Date: _____

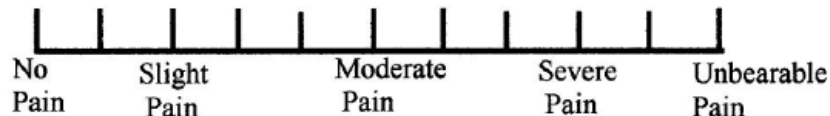
SUBJECTIVE HISTORY

1. Please indicate on the drawing below where you are having pain and what type of pain are you having.

Describe Your Pain	
Is your Pain:	
Numbness	
Burning	
Pins and Needles	
Sharp	
Dull and Aching	
Weakness	



2. Please indicate on the line the intensity of your pain.



3. How long have you had this pain? _____.
4. What makes the pain better: _____
 What makes the pain worse: _____
5. Have you been prescribed any medications for these complaints?
 ___yes ___ no

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or skin patches). Please indicate ALL medications, even those not for this condition:

4. Have you had any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Skin allergies | <input type="checkbox"/> Joint replacement |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy / seizures |
| ___rheumatoid arthritis | <input type="checkbox"/> Osteoporosis |
| ___osteoarthritis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Mastectomy / lymphedema |
| <input type="checkbox"/> Heart disease / problems / congestive heart failure | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Broken bones (fracture) | <input type="checkbox"/> Metal implant |
| <input type="checkbox"/> Kidney disease / renal failure | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Latex allergies |
| <input type="checkbox"/> Breathing difficulties | <input type="checkbox"/> Drug allergies _____ |
| <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Other _____ |

5. Have you ever tested positive for any of the following conditions:

Hepatitis Yes No Tuberculosis Yes No HIV Yes No

6. Have you recently noted any of the following?: (please check if applicable)

- | | |
|--|---|
| <input type="checkbox"/> weight loss/gain | <input type="checkbox"/> weakness/fatigue |
| <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> difficulty breathing |
| <input type="checkbox"/> dizziness/lightheaded | <input type="checkbox"/> fever/chills/ night sweats |
| <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> visual difficulties |
| <input type="checkbox"/> bruising/swelling | <input type="checkbox"/> urinary/bowel changes |
| <input type="checkbox"/> difficulty sleeping | <input type="checkbox"/> chest pain/indigestion |

7. Does your pain change with:

exertion	<input type="checkbox"/> yes	<input type="checkbox"/> no
stress	<input type="checkbox"/> yes	<input type="checkbox"/> no
activity	<input type="checkbox"/> yes	<input type="checkbox"/> no

8. Do you engage in regular exercise? yes no; if yes, what type and how often?

9. Do you have discomfort, shortness of breath, or pain with exercise? yes no

10. Do you use tobacco? yes no; if yes, cigar cigarettes pipe chewing tobacco

11. **Females:** Is there a chance you may be pregnant at this time? yes no

12. Have you ever received physical/occupational therapy before? Yes No

13. What are your goals for physical therapy? _____

14. As of right this minute, are you better the same worse than when you saw your doctor the last time?

15. Are you: working regular duty? working with restrictions? not currently working?

Patient Signature

Date

Therapist Signature

Date