

# Comprehensive Physical Therapy Center, Inc.

## MEDICAL HISTORY/SUBJECTIVE INFORMATION

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

|   |  |  |                      |                            |  |
|---|--|--|----------------------|----------------------------|--|
| <b>Your Name:</b> _____   |  |  |                      | <b>Today's Date:</b> _____ |  |
| <b>Date of Birth:</b> _____   |  | <b>Age:</b> _____  | <b>Height:</b> _____ | <b>Weight:</b> _____       |  |
| <b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female |  | <b>If female, are you currently pregnant?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If yes,</b> <input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup> Trimester |                      |                            |  |

**Who referred you to physical therapy?** \_\_\_\_\_

**Tell Us About Your Condition**

**Where and how did your injury/symptoms occur?**  Recreation  Home  Work  Auto Accident  Unknown  Other

**What activities are limited by this condition?** (E.g. lift, reach) \_\_\_\_\_

**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; 10 = The Most Extreme Pain)

**Worst pain rating:** \_\_\_\_\_ **Best pain rating:** \_\_\_\_\_

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

**Yes/No Please check below:**

Surgery: When? \_\_\_/\_\_\_/\_\_\_ What kind? \_\_\_\_\_

Injection: When? \_\_\_/\_\_\_/\_\_\_ Did it help?  Yes  No

Physical therapy If yes, when? \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_  
 What was done? \_\_\_\_\_

Home Health If yes, when? \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

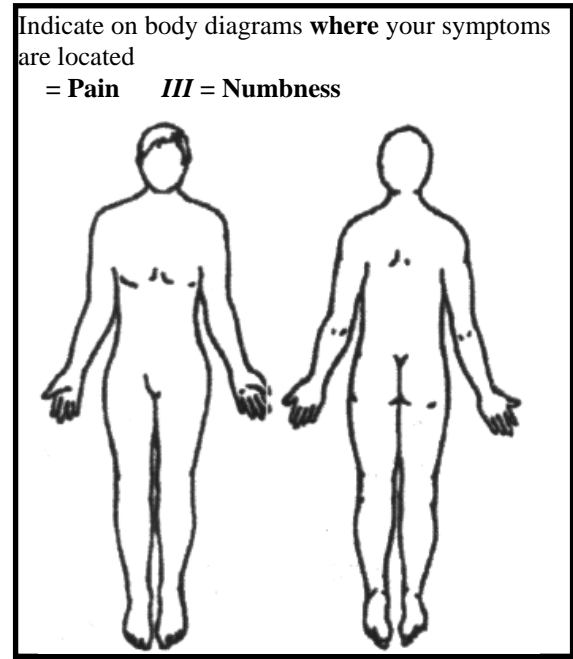
Chiropractor If yes, when? \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_  
 What was done? \_\_\_\_\_

Medications: \_\_\_\_\_

X-ray \_\_\_\_\_   MRI \_\_\_\_\_

CT scan \_\_\_\_\_   Other: \_\_\_\_\_

Exercises: What kind? \_\_\_\_\_  
 Problems with exercise?  No  Yes



**Comments:** \_\_\_\_\_

**Work Information**

Are you currently working?  No  Yes If yes, numbers of hours per week \_\_\_\_\_  Full Duty  Restricted Duty

What are your job responsibilities? \_\_\_\_\_

Estimated return to work date: \_\_\_\_\_

**Your Therapist Will Complete This Section**

Critical work, ADL, or leisure activities affected: \_\_\_\_\_

- Lift/carry:  ≤ 20 lbs. rarely to occasionally  > 20 lbs., or > 1lb. constantly or > 10 lb. frequently \_\_\_\_\_
- Repetitive motions related to condition:  Occasional 1-33%  Frequent to Constant 34-100% \_\_\_\_\_
- Static positions related to condition:  Sit  Stand  Crouch  Kneel  Overhead work \_\_\_\_\_
- Leisure Activities:  None/minimally impact condition  Moderate-high intensity, competitive \_\_\_\_\_

**Additional Comments** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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