

# 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		If female, are you currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, <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? \_\_\_\_\_

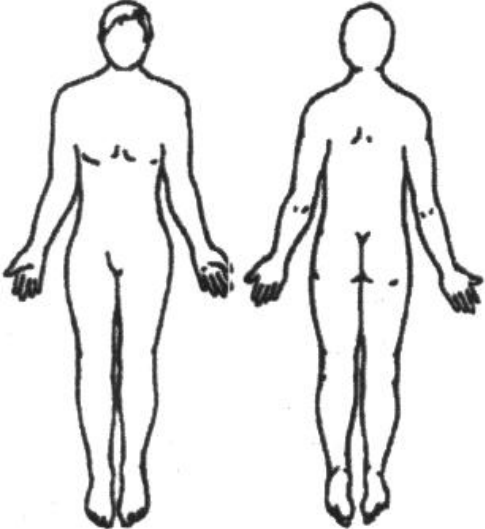
Medications: \_\_\_\_\_

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

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

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

Indicate on body diagrams **where** your symptoms are located   
 = Pain **///** = Numbness



**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** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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