

**PATIENT CURRENT MEDICAL HISTORY SUBJECTIVE INFORMATION FORM Page 1 of 3**

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:** \_\_\_\_\_  
**Sex:**  Male  Female If female, are you currently pregnant?  No  Yes If yes,  1st  2nd  3rd Trimester

**Have you had home health in the past 90 days?**  No  Yes (If yes, with which agency and what date were you discharged? \_\_\_\_\_)

**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?** \_\_\_\_\_

**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 Location: \_\_\_\_\_
- Prior Physical therapy If yes, when? \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_  
What was done? \_\_\_\_\_
- Home Health If yes, when? \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_
- Chiropractor If yes, when? \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_  
What was done? \_\_\_\_\_
- X-ray \_\_\_\_\_
- MRI \_\_\_\_\_
- CT scan \_\_\_\_\_
- NCV (nerve conduction velocity)
- Other: \_\_\_\_\_
- Exercises: What kind? \_\_\_\_\_

**Are your symptoms:**  Constant?  Intermittent?  Getting Better?  Getting worse?  Staying the same?

**Please rate your major area of pain on the 0 – 10 Pain Rating Scale by circling the number of your pain, considering the word descriptors, at the present time and your best and worst over the past 30 days.**

**Pain Scale:** 0    1    2    3    4    5    6    7    8    9    10

\_\_\_\_\_

none worst ever

**Over the past 30 days:**

**BEST:** \_\_\_\_\_ What makes it better? \_\_\_\_\_

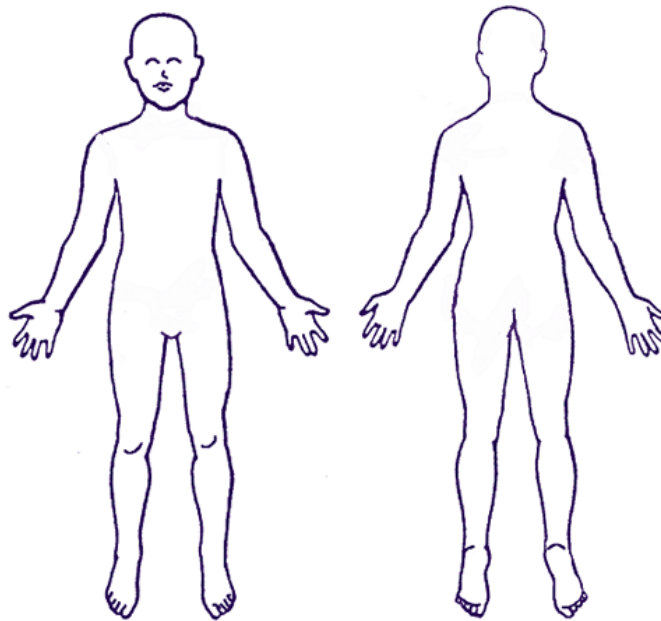
**WORST:** \_\_\_\_\_ What makes it worse? \_\_\_\_\_

**OTHER:** \_\_\_\_\_

\_\_\_\_\_  
 Print Patient Name \_\_\_\_\_ Signature \_\_\_\_\_ Date

**PATIENT MEDICAL HISTORY SUBJECTIVE INFORMATION FORM Page 2 of 3**

Indicate where your pain is located and what type of pain you feel at the present time. Use symbols below to describe your pain as it relates to the current injury or condition for which you seek help:



- ////**    **stabbing**
- xxx**    **burning**
- ooo**    **pins & needles**
- ==**    **numbness**
- ::::**    **ache**

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

- I can lift/carry with no pain or symptoms:  ≤ 10 lbs.  ≤ 15 lbs.  ≤ 20 lbs.  ≤ 30 lbs.  ≤ 40 lbs.
- I need to lift/carry:  ≤ 10 lbs.  ≤ 15 lbs.  ≤ 20 lbs.  ≤ 30 lbs.  ≤ 40 lbs.  ≥ 50 lbs.
- Repetitive motions related to condition:  Occasional 1-33%  Frequent to Constant 34-100%
- Static positions related to condition:  Sit  Stand  Crouch  Kneel  Overhead work  
 other \_\_\_\_\_
- Leisure Activities:  None/minimally impact condition  Moderate-high intensity, competitive

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: \_\_\_\_\_

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

\_\_\_\_\_  
 Print Patient Name

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

**PATIENT MEDICAL HISTORY SUBJECTIVE INFORMATION FORM Page 3 of 3**

**Functional Status/Activity Level** (check all that apply)

- Difficulty with locomotion/movement:
  - Bed mobility
  - Transfers (such as moving from bed to chair, from bed to commode)
  - Gait (walking)
    - on level       ramps
    - on stairs       on uneven terrain
- Difficulty with self-care (such as bathing, dressing, eating, toileting)
- Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)
- Difficulty with community and work activities/integration
  - Work/school
  - Recreation or play activity

**Patient-Specific Activity Scoring Scheme**

List up to six activities that are affected by your symptoms, and then rate how your ability to perform the activity is affected by your symptoms at this time. 0 = unable to perform the activity due to symptoms, 10 = no problem with the activity. Mark on the line, the degree of difficulty you feel you have with the activity because of symptoms. List as many activities as you feel are important.

Activity:

- |    |       |                        |
|----|-------|------------------------|
| 1. | _____ | 0 1 2 3 4 5 6 7 8 9 10 |
| 2. | _____ | 0 1 2 3 4 5 6 7 8 9 10 |
| 3. | _____ | 0 1 2 3 4 5 6 7 8 9 10 |
| 4. | _____ | 0 1 2 3 4 5 6 7 8 9 10 |
| 5. | _____ | 0 1 2 3 4 5 6 7 8 9 10 |
| 6. | _____ | 0 1 2 3 4 5 6 7 8 9 10 |

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date