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Physical Medicine and Rehabilitation

MEDICAL HISTORY AND SUBJECTIVE INFORMATION FORM

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

OUTPATIENT REHABILITATION

Your Name:	Birthdate:	Today's Date:
Do you live: □ Alone	□ With spouse/family:	□ Other:
Chief Complaints:		
Date of Injury/Onset Date:	Admitted to hospital: □ No	□ Yes – date(s):
Describe your injury/condition:		
THERAPIST'S COMMENTS:		

PAIN RATING: Rate your pain on a scale of 0 to 10.

0 = No Pain 10 = Ready to go to the emergency department

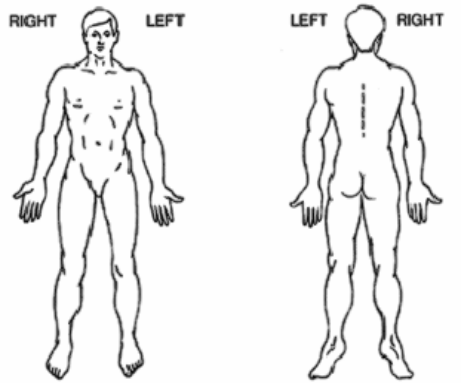
Current:___/10 Best:___/10 Worst: ___/10

What increases your pain?

What decreases your pain?

THERAPIST'S COMMENTS:

Shade in the painful areas below:



PRIOR TREATMENT: For your current injury or condition, have you seen any of the following:

Health Care Provider	Name/Facility/Date	Health Care Provider	Name/Facility/Date
Family Doctor		Occupational Therapist	
Specialist		Physical Therapist	
Psychiatrist/Psychologist		Speech Therapist	
Pain Clinic		Chiropractor	

THERAPIST'S COMMENTS:

Have you had or do you have any of the following conditions?

□ Tuberculosis □ Epilepsy □ Diabetes □ Hearing Loss □ Cataracts □ Dizziness

□ Headaches □ Pneumonia □ Emphysema □ Alcoholism □ Head Injury □ Seizure Disorder

□ Heart Condition □ Stroke □ Hepatitis □ Asthma □ High Blood Pressure

□ Cancer: □ Arthritis: □ Allergies:

□ Are you pregnant? Y N □ Other:

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MEDICATIONS: List any medications you are currently taking:		**THERAPIST'S COMMENTS**
DIAGNOSTIC TESTS: List any diagnostic tests (x-rays, MRI, CT Scan, EMG, blood work, etc.)	**Date of Test**	
SURGERIES: List any surgeries:	**Date of Surgery**	

OCCUPATION: □ Retired: what type of work did you perform?

Are you currently working? N Y If yes, how much? □ Full Duty □ Restricted Duty Hours/Week:

If no, last day worked?

What is your Job Title/ Responsibilities:

What critical work duties/ tasks have been affected by your injury/ condition?

SOCIAL HISTORY:

FUNCTIONAL ACTIVITES: Look at the list below and indicate how your injury or condition has affected your daily life.

1= No problem **2=** Can do with some difficulty **3=** Can do with great difficulty **4=** Can NOT do

Circle the number next to each activity that best applies to your ability to function.

PLEASE CIRCLE YOUR RESPONSES BELOW:

SITTING	**1 2 3 4**	**EATING/ SWALLOWING**	**1 2 3 4**
STANDING	**1 2 3 4**	**BATHING**	**1 2 3 4**
SQUATTING	**1 2 3 4**	**DRESSING**	**1 2 3 4**
GOING UP OR DOWN STAIRS	**1 2 3 4**	**GROOMING**	**1 2 3 4**
WALKING	**1 2 3 4**	**TOILETING**	**1 2 3 4**
TRANSFERRING POSITIONS (sitting to standing, etc.)	**1 2 3 4**	**COORDINATION** (buttoning, tying, fastening, writing, etc.)	**1 2 3 4**
SPORTS/RECREATION	**1 2 3 4**	**REACHING**	**1 2 3 4**
DRIVING A VEHICLE	**1 2 3 4**	**GRIPPING**	**1 2 3 4**
LYING DOWN	**1 2 3 4**	**MOVEMENT OF MOUTH/ JAW**	**1 2 3 4**
SLEEPING AT NIGHT	**1 2 3 4**	**HOUSEWORK/ YARDWORK**	**1 2 3 4**
LIFTING/ CARRYING	**1 2 3 4**	**ABILITY TO SPEAK**	**1 2 3 4**
DAILY JOB ACTIVITES	**1 2 3 4**	**ABILITY TO UNDERSTAND WHAT IS SAID**	**1 2 3 4**
READING/ WRITING	**1 2 3 4**	**OTHER:**	**1 2 3 4**

What do you want to achieve in therapy?

Patient's Signature/ Date:	Therapist(s) Signature/ Date: