

Medical History/Subjective Information

Name: _____ Date: _____ Birthdate: _____ Age: _____

Height: _____ Weight: _____ Referring Physician: _____

Medical History (check all that apply)

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Visual Impaired	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Cancer
<input type="checkbox"/> Depression	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Stroke
<input type="checkbox"/> Weight Loss of more than 10 lbs recently			

Therapist's Comments: _____

Have you had surgery for your condition? **Y** **N** If yes, please give approximate date: _____

Have you had any injections for your condition **Y** **N** If yes, please give approximate date: _____

Please list any diagnostic test you have had for this condition: _____

Please list any **medications** that you are taking: _____

What are your current symptoms? _____

When did the injury of symptoms occur?

_____ First episode _____ Second episode _____ Third episode

How did the injury or problem occur? _____

Please rate your pain using a 0-10 scale (0=no pain, 10 = the worst pain you can imagine)

Worst pain since onset _____ **Best** pain since onset _____ **Today's** pain _____

Where is your pain or problem located? _____

Is your pain? Constant Intermittent

What makes your pain/problem **better**? _____ **Worse**? _____

Is there pain present at night? **Y** **N** What position helps you sleep? _____

Therapist's Comments: _____

Would you like to speak to someone regarding abuse or neglect that you have recently experienced? **Y** **N**

Employment History

Are you currently working? **Y** **N** If no, how many total days of work have you missed? _____

Are your work duties Restricted Full How many hours per week do you work? _____

Who is your employer? _____

What type of work do you do? _____

What critical work duties have been most affected by your problem? _____

What do you hope to accomplish with therapy? _____

Please complete the following page 

Please rate your abilities using the following scale:

