

# superior

## PHYSICAL THERAPY

### MEDICAL HISTORY AND SUBJECTIVE INFORMATION FORM

Please answer the following questions as completely as possible. **Please** use **black ink only**, and **do not** fill in shaded areas. Shaded areas are for **OFFICE USE ONLY**. If you need help filling out this form, we would be happy to assist you.

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_

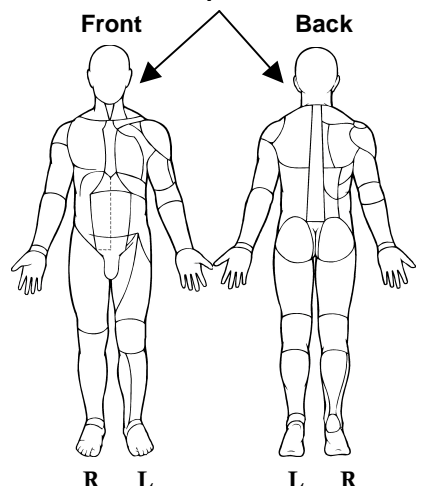
*Date of injury/problem:	*Date you went to your doctor for help with this injury/problem:
*Briefly describe how your problem occurred. (Include dates if possible.)	

<b>Therapist Comments</b>

When are you scheduled to return to your doctor? <input type="checkbox"/> Not Scheduled <input type="checkbox"/> _____
*What would you like to accomplish in therapy (what are your goals)?

Rate your pain on a scale from 0-10 (0=no pain, 10=worst pain): *Current____ *Best____ *Worst____
Describe your pain: <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent <input type="checkbox"/> Sharp/Stabbing <input type="checkbox"/> Dull /Aching <input type="checkbox"/> Burning <input type="checkbox"/> Throbbing <input type="checkbox"/> Other:

<b>What makes your Pain/Symptoms...</b>
*Better (or decreases your pain): _____
*Worse (or increases your pain): _____
When are your symptoms better: <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Other: _____
When are your symptoms worse: <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Other: _____
Does your pain wake you? <input type="checkbox"/> No <input type="checkbox"/> Yes: _____
Do you sleep through the night? <input type="checkbox"/> No <input type="checkbox"/> Yes: _____
*Do you have numbness? <input type="checkbox"/> No <input type="checkbox"/> Yes, location: _____
*Do you have tingling? <input type="checkbox"/> No <input type="checkbox"/> Yes, location: _____

<b>*Please shade in the painful areas below:</b>
<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>Front</p>  <p>R L</p> </div> <div style="text-align: center;"> <p>Back</p> <p>L R</p> </div> </div>

<b>Therapist Comments</b>

**\*PREVIOUS TREATMENT (S)** for this condition (please check all that apply):  None

Health Care Provider	Name / Date	Health Care Provider	Name / Date
<input type="checkbox"/> Family Doctor		<input type="checkbox"/> Physical Therapist	
<input type="checkbox"/> Specialist		<input type="checkbox"/> Occupational Therapist	
<input type="checkbox"/> Psychiatrist/Psychologist		<input type="checkbox"/> Speech Therapist	
<input type="checkbox"/> Pain Clinic		<input type="checkbox"/> Chiropractor	

<b>Therapist Comments:</b> <input type="checkbox"/> Prior treatment reviewed
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**\*DIAGNOSTIC TEST (S):** Have you had any of the following for your current condition? (If yes, please check and state results.)

Test	Date / Result	Test	Date / Result
<input type="checkbox"/> None		<input type="checkbox"/> MRI	
<input type="checkbox"/> X-rays		<input type="checkbox"/> EMG	
<input type="checkbox"/> CT scan		<input type="checkbox"/> Other	

<b>Therapist Comments:</b> <input type="checkbox"/> Prior tests reviewed
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**\*MEDICAL HISTORY:**\*Any past surgeries?  No  Yes, please list and date:(Please check each box that applies)  Reviewed with patient (Unremarkable)

Have you had any of the following:

Is there any chance you may be pregnant?  No  Yes, \_\_\_\_\_ # of months

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Heart disease/attack   | <input type="checkbox"/> Lung disease/asthma             | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Arthritis (type: _____)  |
| <input type="checkbox"/> Pacemaker/defibrillator  | <input type="checkbox"/> Kidney disease                  | <input type="checkbox"/> Head injury          | <input type="checkbox"/> Osteoporosis/osteopenia  |
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Liver disorder/hepatitis: _____ | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Metal implants           |
| <input type="checkbox"/> Circulation problems   | <input type="checkbox"/> Thyroid disease                 | <input type="checkbox"/> Seizures             | <input type="checkbox"/> Stomach disorders        |
| <input type="checkbox"/> Diabetes (type: _____)   | <input type="checkbox"/> Skin disease                    | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Frequent nausea/vomiting |
| <input type="checkbox"/> Blood issues/history of clot   | <input type="checkbox"/> Cancer (type: _____)            | <input type="checkbox"/> Swallowing problems  | <input type="checkbox"/> Bowel/bladder issues     |
| <input type="checkbox"/> HIV (+)  | <input type="checkbox"/> MRSA/VRE(+)                     | <input type="checkbox"/> Mental health issues | <input type="checkbox"/> Neuromuscular disease    |
| <input type="checkbox"/> Shingles (current / history of)  |  |   |   |
| <input type="checkbox"/> Other medical history that we need to be aware of, i.e., accidents or other? _____ |  |   |   |

Hearing loss:  No  Yes      Hearing aids:  No  Yes      Glasses/Contact lens:  No  YesAllergies to:  None  Tape/Latex  Adhesive  Environmental  Drug Type \_\_\_\_\_Do you smoke?  No  Yes, how many packs/day: \_\_\_\_\_      Do you drink alcohol?  No  Yes, how much: \_\_\_\_\_\*List all current medications including over-the-counter types (If you have a list, we will photocopy it.):  None**Therapist Comments:****\*EMPLOYMENT:**Are you currently working?  Full-time  Part-time  Retired  Disabled  Student  Unemployed

Occupation / Job Title / Responsibilities: \_\_\_\_\_

List any restrictions: \_\_\_\_\_

What problems are you having at work due to your condition: \_\_\_\_\_

List any hobbies: \_\_\_\_\_

**Therapist Comments: (Return to work goals: Industrial Rehab, disability, restrictions, lifestyle, hobbies, home life.)****PERSONAL INFORMATION/ACTIVITIES OF DAILY LIVING:**

Home:  1-story with/without basement     2-story home with/without basement  
 Apartment with/without elevator     Mobile Home  
 Other: \_\_\_\_\_

Stairs: Maximum # of stairs in your home: \_\_\_\_\_

When going up the stairs, are handrails on the:

 Left  Right  Both  NoneLives (with):  Spouse  Alone  Family  Friend(s)  Other \_\_\_\_\_**Therapist Comments:**Equipment: Equipment used at home (lift chair, bathroom rails, etc):  None  Yes, equipment used: \_\_\_\_\_Prior to this, did you walk using a device?  No  Cane  Crutches  Standard Walker  Rolling Walker  Other: \_\_\_\_\_Falls: Number of falls you have had in the last month/year?  None  Yes (If yes, number of falls last month: \_\_\_\_\_ / last year: \_\_\_\_\_)What is your primary language?  English  Other \_\_\_\_\_Needs: Do you have any additional needs?  No  Yes (If yes, check all that apply)  Large Print  Nutrition Counsel Interpreter for \_\_\_\_\_ language  Cultural/Religious  Counseling  Support Groups  Other: \_\_\_\_\_

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Please review the list below and rate those tasks that your condition affects using the scoring guide below.  
**Only rate those tasks that apply to you.**

**SCORING GUIDE**

0=Able to perform at the same level  
as before injury or problem

0 1 2 3 4 5 6 7 8 9 10

10=Unable to perform activity

Please circle your responses below

TASKS	RATING (0-10)	THERAPIST COMMENTS
Sitting		
Standing		
Walking		
Running		
Stairs		
Balancing		
Kneeling		
Bending / Stooping		
Jumping / Hopping		
Sleeping		
Positional changes in bed		
Getting in/out of bed, chairs, car, etc.		
Driving including fastening seatbelt		
Housekeeping		
Yard work		
Job responsibilities including computer work		
Leisure tasks		
Pulling / Pushing / Reaching		
Lifting / Carrying		
Personal care (grooming, bathing, dressing, toileting, etc.)		
Gripping / Grasping		
Coordination (upper or lower body)		
Eating / Swallowing		
Speaking		
Understanding Speech		
Writing		
Reading		
Other:		
Other:		

**ADDITIONAL COMMENTS:** History reviewed with patient: Yes No

Patient's signature/date:

\*Therapist(s) signature/date/time: