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.)**

Therapist Comments

When are you scheduled to return to your doctor? ☐ Not Scheduled ☐ ____________________

***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: ☐Constant ☐Intermittent ☐Sharp/Stabbing ☐Dull /Aching ☐Burning ☐Throbbing ☐Other:

What makes your Pain/Symptoms…

*Better (or decreases your pain):____________________

*Worse (or increases your pain):____________________

When are your symptoms better: ☐AM ☐PM ☐Other:____________

When are your symptoms worse: ☐AM ☐PM ☐Other:____________

Does your pain wake you? ☐No ☐Yes: ____________

Do you sleep through the night? ☐No ☐Yes: ____________

*Do you have numbness? ☐No ☐Yes, location: ____________

*Do you have tingling? ☐No ☐Yes, location: ____________

Therapist Comments

***Please shade in the painful areas below:**

Front Back

R L L R

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

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

Therapist Comments: ☐ **Prior treatment reviewed**

***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
☐ None		☐ MRI	
☐ X-rays		☐ EMG	
☐CT scan		☐ Other	

Therapist Comments: ☐ **Prior tests reviewed.**

Last Revision: 4.14.21

Office Use Only

***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

☐Heart disease/attack ☐Lung disease/asthma ☐Stroke ☐Arthritis (type: ___________)
☐Pacemaker/defibrillator ☐Kidney disease ☐Head injury ☐Osteoporosis/osteopenia
☐High blood pressure ☐Liver disorder/hepatitis: _____ ☐Headaches ☐Metal implants
☐Circulation problems ☐Thyroid disease ☐Seizures ☐Stomach disorders
☐Diabetes (type: ____________) ☐Skin disease ☐Dizziness ☐Frequent nausea/vomiting
☐Blood issues/history of clot ☐Cancer (type: ______________) ☐Swallowing problems ☐Bowel/bladder issues
☐HIV (+) ☐MRSA/VRE(+) ☐Mental health issues ☐Neuromuscular disease
☐ Shingles (current / history of)

☐**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 ☐Yes

Allergies 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 ☐None

Lives (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: __________________

***Patient's signature/date:**

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

Superior Physical Therapy Policies

1. **Appointment Times:**
   Please arrive 10 minutes prior to your scheduled appointment.

2. **24 hour Cancellation Policy:**
   a. **If you do not cancel your appointment within the 24 hour advanced notice we will charge your account a $50.00 fee. Please call the office during business hours to cancel, do not email.**

3. **Missed / NO SHOW Appointment Fee:**
   a. **There will be a $50.00 fee charged to your account if you do not give 24 hour advanced notice.**
   b. **The FIRST no show will be charged the $50 fee and we will need to hear from you by 5pm the day of your no show to confirm you will be attending your next scheduled appointment. The SECOND no show will result in the cancellation of your remaining appointments *unless* we hear from you by the end of the business day.**

4. **Insurance and Claim Submission:**
   We do participate with many various insurance companies. As a courtesy, we will bill most insurance companies for our patients. Please understand that your insurance coverage is an agreement between you and your insurance company. Knowing your insurance benefits is your responsibility.

5. **Copay, Deductibles and Co-Insurance Collection:**
   a. **We collect all copays at the date of service per your insurance verification provided.**
   b. **Copays, deductibles and co-insurances are the out of pocket expenses you are responsible for.**

Signature/Date:____