SUBURBAN ORTHOPAEDIC, TOTAL JOINT & SPORTS CLINIC, P.C.
PT Department
Subjective Report/PMHX Form

For Internal Use Only:
Patient Name:_____ **Date of Eval:**_____
Date of Birth: _____**Sex:**_____ **Date of Onset:** _____
Diagnosis: L//R/B_____ **Surgical Procedure:** _____
Referring Physician: _____ **Date of Surgery:** _____

Please answer the following questions pertaining to your CURRENT medical condition: ***Therapist Comments:***

Subjective History:

What is your date of injury/onset of symptoms? _____

How did you injure yourself? _____
_____

Have you had any of the following? ☐ **X-rays** ☐**CT Scan** ☐ **MRI** ☐ **EMG/Nerve Conduction Test**

☐**Other** _____ **When is your next Doctor's visit?** _____

Have you had any prior occurrences of this condition? ☐ **Yes** ☐ **No**
If yes, explain _____

Have you had any prior treatment for this injury? ☐ **Yes** ☐ **No**
If yes, explain: _____

Current Complaints:

What is your chief complaint? _____
_____
What makes your pain BETTER? _____
What makes your pain WORSE? _____

Functional/ADL Ability Restrictions: PLEASE COMPLETE ATTACHED FUNCTIONAL OUTCOME TOOLS

Prior Level of Function: **What were you able to do prior to this injury that you are not able to do presently?**
_____

Pain Rating:

If you have pain, what is your pain level? **(0 = No Pain, 10 = Extreme Pain)**

Pain Level at WORST: (Circle)

0 1 2 3 4 5 6 7 8 9 10

CURRENT Pain Level : (Circle)

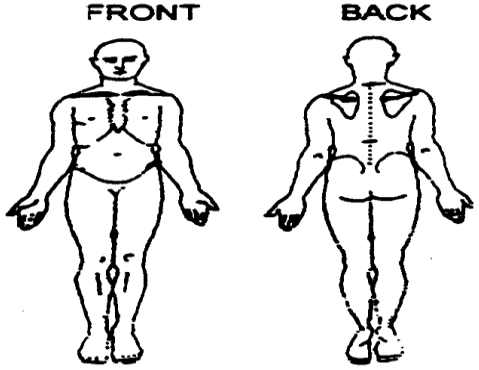
0 1 2 3 4 5 6 7 8 9 10

Pain Level at BEST: (Circle)

0 1 2 3 4 5 6 7 8 9 10

If you do have pain, please describe your symptoms to the best of your ability (ie: numbness, tingling, pins and needles, etc) _____

Mark the location of your pain with an "X":



Hand Dominance: ☐**Right or** ☐**Left**

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Patient Name:_____ **Date:**_____

Please answer the following questions pertaining to your CURRENT medical condition: ***Therapist Comments:***

Occupation/Work Status:

What is your occupation? _____ Are you presently working? ☐Yes ☐No

If Yes, □ Full □Limited Duty Explain: _____

Lost days from work to date: _____ Days of work restriction to date: _____

Are you now, or ever have been disabled (service or work)? □ Yes □ No If yes, when? _____

Social History/Interests/Living Environment:

Do you live: ☐ Alone ☐ With spouse ☐ With family ☐ Other _____

Do you have stairs? ☐ Yes ☐ No If yes, how many? _____ Do stairs have handrail? ☐ Yes ☐ No

Do you have any home fall hazards such as throw rugs, poor lighting, etc? ☐ Yes ☐ No _____

How are your interests/hobbies affected by your symptoms? _____

_____

Previous Medical History/General Health/Prior Hospitalizations:

How would you classify your general health?

□ Good □ Fair □ Poor

Do you have, or have you ever had any of the following?

□ Allergies	□ Fibromyalgia	□ Liver/Gallbladder Problem	□ Recent Fractures
□ Anemia	□ Headaches	□ Metal Implants	□ Rheumatoid Arthritis
□ Asthma/Breathing Difficulties	□ Heart Attack	□ Nausea/Vomiting	□ Ringing of the Ears
□ Bowel/Bladder Abnormalities	□ Heart Disease	□ Night Pain	□ Seizures/Epilepsy
□ Cancer	□ Heart Palpitations	□ Osteoarthritis	□ Sexual Dysfunction
□ Chest Pain/Angina	□ Hernia	□ Osteoporosis	□ Skin Abnormalities
□ Depression	□ High/Low Blood Pressure	□ Pacemaker	□ Smoking History
□ Diabetes I or II	□ Hypoglycemia	□ Physical Abnormalities	□ Stroke/TIA
□ Dizziness/Fainting	□ Intolerance to Cold/Heat	□ Polio	□ Surgeries
□ Fever	□ Kidney Problems	□ Pregnancy (Currently)	□ Urine Leakage
			□ Vision Changes

Is there any other information regarding your medical history that we should know about? _____

_____

Medical Precautions/Contraindications:

Are there any factors that may complicate your ability to participate in therapy? ☐Yes ☐ No

If Yes, please explain: _____

Have you fallen in the past 12 months? ☐Yes ☐ No If yes, how many times? _____

If yes, please describe the nature of the fall(s) and if an injury(ies) occurred: _____

Do you currently or have you in the past used an assistive device to walk with? ☐ Yes ☐ No

If yes, list the assistive device (ie: cane, walker, wheelchair, etc.) _____

Medications:

Please list all of the medications (with specific dosages) that you are currently taking (including Over-The-Counter, prescriptions, herbals, and vitamins/minerals:)

_____

_____

Patient's Goals for PT/OT:

What are your goals for participating in therapy? _____

_____

To the best of my knowledge, I have fully informed you of the history of my problem and current status.

Patient Signature: _____ Date: _____

Therapist Signature:_____ Date: _____