

SUBURBAN ORTHOPAEDIC, TOTAL JOINT & SPORTS CLINIC, P.C.

PT Department

Subjective Report/PMHX Form

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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)



CURRENT Pain Level: (Circle)



Pain Level at **BEST**: (Circle)

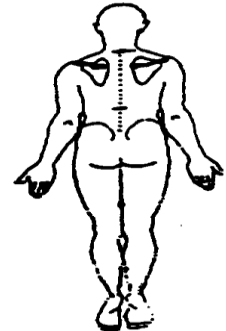
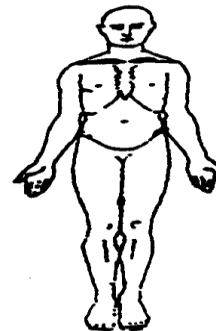


If you do have pain, please describe your symptoms to the best of your ability (ie: numbness, tingling, pins and needles, etc) _____

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

FRONT

BACK



Hand Dominance: Right or Left

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(page 2 of 2)

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?

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