INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET (Page 1)

Patient Name: _____ **Date of Birth:** _____ **Date of Eval:** _____

SUBJECTIVE

Age: _____ **When did your symptoms start?** _____

Hand Dominance: ☐Right ☐Left **Date of next Doctor's appointment:** _____

Describe the current problem that brought you here: _____

_____

Are your symptoms: ☐Improving ☐Getting Worse ☐Staying the Same

Have you had any testing? ☐X-rays ☐MRI ☐EMG/ Nerve Conduction Test ☐CT Scan

☐Other **Results:** _____

Have you ever had these symptoms before? ☐Yes ☐No **Description:** _____

Have you ever had treatment before for these symptoms? ☐Yes ☐No **If Yes, please describe:**

☐**Medication:** **Beneficial?** ☐Yes ☐No **Explain:** _____

☐**Injection:** **Beneficial?** ☐Yes ☐No **Explain:** _____

☐**Physical Therapy:** **Beneficial?** ☐Yes ☐No **Explain:** _____

☐**Massage/Chiropractic:** **Beneficial?** ☐Yes ☐No **Explain:** _____

Did you have surgery? ☐Yes ☐No **Date of Surgery:** _____

If yes, what procedure did you have done? _____

Have you ever purchased or rented Durable Medical Equipment, Orthotics, Prosthetics, or Supplies?

☐Yes ☐No **Explain:** _____

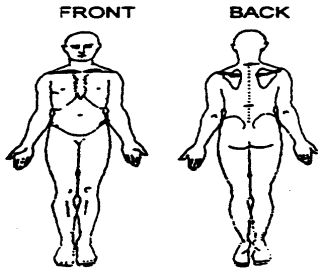
THERAPIST COMMENTS:

CURRENT COMPLAINTS

If you have pain, what is your pain level?

(0 = No Pain, 10 = Extreme Pain – Circle)

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



AT WORST: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

AT BEST: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

CURRENTLY: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Are your symptoms: ☐Constant ☐Come and Go ☐Ache ☐Deep ☐Superficial ☐Dull ☐Sharp ☐Shooting ☐Burning ☐Numbness/Tingling ☐Other: _____

Day Pattern:

Does your pain seem to be WORSE at a certain time of day? ☐Yes ☐No

If Yes, ☐Morning ☐Night ☐Other: _____

Does your pain progress as the day goes along? ☐Yes ☐No

If Yes, please explain: _____

Do you have difficulty falling asleep? ☐Yes ☐No **If Yes, please explain:** _____

Do you wake due to pain? ☐Yes ☐No **If Yes, # of times per night:** _____

THERAPIST COMMENTS:

FUNCTIONAL ABILITIES AND RESTRICTIONS

What were you doing prior to this injury that you are unable to do currently? Please list any additional activities that you are having difficulty completing. _____

☐Squatting ☐Sitting ☐Driving ☐Reaching ☐Work Tasks ☐Gripping/Pinching
☐Standing ☐Walking ☐Lifting ☐Dressing/Grooming ☐Stairs ☐Position Changes
☐Kneeling ☐Holding/Carrying Objects
☐Other: _____

What activities make your pain WORSE? _____

What activities make your pain BETTER? _____

What household duties are you having difficulty performing? ☐Cooking ☐Cleaning ☐Vacuuming ☐Laundry ☐Yard Work ☐Grocery Shopping ☐Other: _____

Do you use an assistive device? ☐None ☐Cane ☐Walker ☐Wheelchair ☐Other: _____

Did you use an assistive device prior to current injury/conditions? _____

Hobbies/ Interests/ Exercise: _____

THERAPIST COMMENTS:

Patient Name: _____ **Date of Birth:** _____ **Date of Eval:** _____

WORK HISTORY/ SOCIAL HISTORY/ INTERESTS/ LIVING ENVIRONMENT

Occupation: _____ **Presently Working:** ☐ **Yes** ☐ **No**

If Yes, ☐ **Full Duty** ☐ **Limited Duty: Restrictions:** _____ **# Days Off Work:** _____

Job Duties: ☐ **Sitting** ☐ **Computer Work** ☐ **Bending** ☐ **Heavy Lifting** ☐ **Traveling** ☐ **Standing**
☐ **Reaching** ☐ **Crawling** ☐ **Twisting** ☐ **Walking** ☐ **Pushing/Pulling**
☐ **Gripping/Pinching** ☐ **Other:** _____

Are you now, or have you ever been disabled (service or work)? ☐ **Yes** ☐ **No** **If Yes, when?** _____
If Yes, please explain: _____

What is your current living arrangement? ☐ **Alone** ☐ **Spouse** ☐ **Partner** ☐ **Family** ☐ **Other:** _____

Does your home have stairs? ☐ **Yes** ☐ **No** **If Yes, # of stairs:** _____

If Yes, do your stairs have handrail? ☐ **Yes** ☐ **No** **If Yes, which side going up?** ☐ **Right** ☐ **Left** ☐ **Both**

THERAPIST COMMENTS:

PREVIOUS MEDICAL HISTORY/ MEDICAL PRECAUTIONS AND CONTRAINDICATIONS

How would you classify your general health? ☐ **Good** ☐ **Fair** ☐ **Poor**

In terms of your general health, please check ALL that apply:

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

Is there any other information regarding your medical history or are there any factors that may complicate your ability to participate in therapy that we should know about?

Have you had any falls in the past 12 months? ☐ **Yes** ☐ **No** **If Yes, how many times?** _____
If Yes, please describe the nature of the fall (s):
If Yes, please describe if an injury(ies) occurred:

THERAPIST COMMENTS:
☐ **See Attached List**

MEDICATIONS

Please list all of the medications [*with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)*] that you are currently taking [including over-the-counter, prescriptions, herbals, and vitamins/mineral(s)]:

THERAPIST COMMENTS:
☐ **See Attached List**

PATIENT GOALS FOR THERAPY

What are your goals for participating in Therapy? (I.E: performing household tasks without pain)

THERAPIST COMMENTS:

SIGNATURES

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

Patient's Signature: _____ **Date:** _____
Therapist's Signature: _____ **License #:** _____ **Date:** _____
Printed Therapist's Name: _____