PRN Torrance Physical Therapy

MEDICAL HISTORY/SUBJECTIVE INFORMATION

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Your Name:				**Today's Date:**
Date of Birth:	**Age:**	**Height:**	**Weight:**	**Do You Smoke?** ☐ **Yes** ☐ **No**

Sex: ☐ **Male** ☐ **Female** **If female,** are you currently pregnant? ☐ **No** ☐ **Yes** **If yes,** ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester

Have you ever been diagnosed with any of the following?

Tuberculosis	☐ No	☐ Yes	Cancer	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Heart Condition	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes	Respiratory Problems	☐ No	☐ Yes

Other: ______

Who referred you to physical therapy? ______

Primary Physician ______

Tell Us About Your Condition

When did you first notice the pain or have functional problems due to the condition/injury? (Please provide approximate dates): ______

Recent flare-up? ☐ No ☐ Yes If yes, when ______

What activities are limited by this condition? (e.g. lift, reach): ______

How did your injury/symptoms occur? ______

What do you expect to accomplish with physical therapy? ______

Are your symptoms: ☐ Constant? ☐ Intermittent? ☐ Getting Better? ☐ Getting worse? ☐ Staying the same?

What makes your symptoms better? ______

0-10 pain scale (0 = No Pain; 5= Moderate Pain; 10 = The Most Extreme Pain)

Worst pain rating: 0 1 2 3 4 5 6 7 8 9 10

Best pain rating: 0 1 2 3 4 5 6 7 8 9 10

For this injury, has your medical care included: (check those that apply)

☐ Surgery: When? ___/___/___ What kind? ______

☐ Injection: When? ___/___/___ Did it help? ☐ Yes ☐ No

☐ Other treatment:

- ☐ Physical therapy If yes, when? ___/___/___ to ___/___/___
  What was done? ______
- ☐ Chiropractor If yes, when? ___/___/___ to ___/___/___
  What was done? ______
- ☐ Medications: ______
- ☐ X-ray ______ ☐ MRI ______
- ☐ CT scan ______ ☐ Other: ______
- ☐ Exercises: What kind? ______

Indicate on body diagrams **where** your symptoms are located

■ = Pain *III* = Numbness

Comments: ______

Effective: January 2013

Torrance PT

Work Information

Who is your employer? ____________________

What is your job title/responsibilities? ____________________

Are you currently working? ☐ No ☐ Yes If yes, numbers of hours per week ____________________

☐ Full Duty ☐ Restricted Duty

How many total work days have you missed? ______ Do you have a case manager/QRC? ☐ No ☐ Yes

Your Therapist Will Complete This Section

Critical work, ADL, or leisure activities affected: ____________________

- Lift/carry: ☐ ≤ 20 lbs. rarely to occasionally (**low demand**)
  ☐ > 20 lbs., or > 1lb. constantly or > 10 lb. frequently (**mod-high demand**)
  Where to where ______________ to ______________.
- Repetitive motions related to condition: ☐ Occasional 1-33% (**low demand**)
  ☐ Frequent to Constant 34-100% (**mod-high demand**)
- Static positions related to condition (**mod-high**): ☐ Sit ☐ Stand ☐ Crouch
  ☐ Kneel ☐ Overhead work ☐ ______________
- Leisure Activities: ☐ None/minimally impact condition **(low demand)**
  ☐ Moderate-high intensity, competitive (**mod-high demand)**

Overall functional demand (work/ADL/leisure) ☐ Low Demand ☐ Moderate-High Demand

Comments: ____________________

Additional Comments: ____________________

Indicate either "Yes" or " No" as to whether each of the following activities is difficult.

Activity	Answer
Drinking or Eating	☐ Yes ☐ No
Sleeping Through the Night	☐ Yes ☐ No
Dressing: Putting on or taking off shoes, socks, shirt, jacket or pants	☐ Yes ☐ No
Maintaining static position of; Head bent forward, arms overhead, arms forward, or turning head	☐ Yes ☐ No
Getting in/out of: chairs, bed, car or bath/shower	☐ Yes ☐ No
Reaching: overhead, behind back, downward for forward	☐ Yes ☐ No
Gripping, Holding tools or Opening Jars	☐ Yes ☐ No
Picking up Small Objects	☐ Yes ☐ No
Sitting	☐ Yes ☐ No
Standing	☐ Yes ☐ No
Job Related Activities	☐ Yes ☐ No

Activity	Answer
Balancing on both feet	☐ Yes ☐ No
Walking on: stairs, flat surfaces, inclines, uneven surfaces, ladders	☐ Ye ☐ No
Lifting	☐ Yes ☐ No
Carrying	☐ Yes ☐ No
Bending, Kneeling Squatting	☐ Yes ☐ No
Driving a vehicle or ability to use gas/brake pedals	☐ Yes ☐ No
Caring for child or adult	☐ Yes ☐ No
Housework / Yard work	☐ Yes ☐ No
Recreational Activities	☐ Yes ☐ No
Have you fallen more than 1 time in the past year	☐ Yes ☐ No
Have you fallen and hurt yourself in the past year	☐ Yes ☐ No

Other:

Effective: January 2013

Torrance PT

CURRENT MEDICATIONS LIST REPORT

PATIENT NAME:

DATE:

LIST ALL THE PRESCRIPTION MEDICATIONS YOUR ARE CURRENTLY TAKING

NAME OF THE MEDICATION	DOSAGE (how many or how much you take)	FREQUENCY (how often do you take it)	ROUTE (how do you take it, i.e., by mouth, injection etc.)

LIST ALL OVER-THE -COUNTER MEDICATIONS

NAME OF THE MEDICATION	DOSAGE (how many or how much you take)	FREQUENCY (how often do you take it)	ROUTE (how do you take it, i.e., by mouth, injection etc.)

LIST ALL HERBALS, VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS

NAME OF THE MEDICATION	DOSAGE (how many or how much you take)	FREQUENCY (how often do you take it)	ROUTE (how do you take it, i.e., by mouth, injection etc.)

Effective: January 2013