PTSMI

Physical Therapy & Sports Medicine Institute, LLC
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 and Where 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)

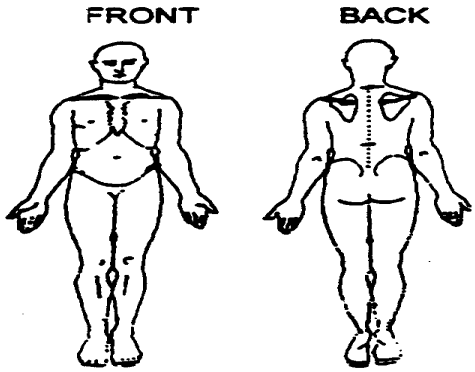
0 1 2 3 4 5 6 7 8 9 10

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:**_____

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