

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)



**CURRENT** Pain Level: (Circle)

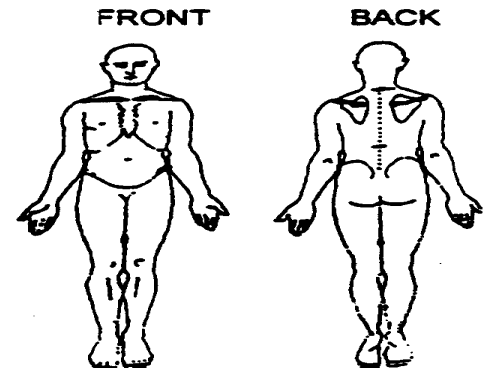


Pain Level at **BEST**: (Circle)



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":



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 [ ] 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: \_\_\_\_\_