

**MEDICAL HISTORY AND SUBJECTIVE INFORMATION FORM**

Please answer the following questions as completely as possible.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Three Rivers Therapy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of injury/problem:** | | | |
| **Briefly describe how your injury occurred:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **What would you like to accomplish in therapy:** | | | |
| **Rate your pain on a scale of 0-10 (0=no pain, 10=emergency room worthy pain):** \*\***Best**\_\_\_\_\_\_\_\_ \*\***Worst** \_\_\_\_\_\_\_\_\_ | | | |
| **Describe your pain: ⃝Constant ⃝Intermittent ⃝Sharp/Stabbing ⃝Dull/Aching ⃝Burning ⃝Throbbing ⃝Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **What makes your Pain/Symptoms…**  D026C2DA\*\*Better (or decreases your pain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \*\*Worse (or increases your pain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  When are your symptoms better: ⃝AM ⃝PM ⃝Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  When are your symptoms worse: ⃝AM ⃝PM ⃝Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Does your pain wake you: ⃝No ⃝Yes, Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you have numbness: ⃝No ⃝Yes, Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Previous Treatment(s) for this condition (please check all that apply: or ⃝None** | | | |
| **Health Care Provider** | **Date** | **Health Care Provider** | **Date** |
| ⃝Family Doctor |  | ⃝Physical Therapist |  |
| ⃝Specialist |  | ⃝Occupational Therapist |  |
| ⃝Psychiatrist/Psychologist |  | ⃝Speech Therapist |  |
| ⃝Pain Clinic |  | ⃝Chiropractor |  |
| **Diagnostic Tests: Have you had any of the following for your current condition: (If yes, please check and state results below):⃝None** | | | |
| ⃝X-Rays |  | ⃝MRI |  |
| ⃝CT Scan |  | ⃝EMG |  |
| ⃝Other |  | ⃝Other |  |

Page 1 of 2

**MEDICAL HISTORY AND SUBJECTIVE INFORMATION FORM**

Please answer the following questions as completely as possible.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



|  |  |  |  |
| --- | --- | --- | --- |
| **Medical History:**  Any past surgeries: ⃝No ⃝Yes. Please list and date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Please check each box that applies:**  Have you had any of the following: ⃝None  ⃝Heat disease/attack ⃝Lung disease/asthma ⃝Stroke ⃝Arthritis (type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ⃝Pacemaker/defibrillator  ⃝Kidney disease ⃝Head injury ⃝Osteoporosis/osteopenia ⃝High blood pressure ⃝Liver disorder/hepatitis  ⃝Headaches ⃝Metal implants ⃝Circulation problems ⃝Thyroid disease ⃝Seizures ⃝Stomach disorders  ⃝Diabetes (type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ⃝Skin disease ⃝Dizziness ⃝Frequent nausea/vomiting ⃝Blood issues/history of clot  ⃝Cancer (type:\_\_\_\_\_\_\_\_\_\_\_\_\_) ⃝Swallowing problems ⃝Bowel/bladder issues ⃝HIV (+) ⃝MRSA/VRE (+)  ⃝Mental Health issues Neuromuscular disease  Other history we need to be aware of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Occupation/Job Title/Responsibilities: ⃝N/A | | | |
| List problems you are having at work due to your condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **FALLS:** list the number of falls you have recently had: ⃝None ⃝Yes (If yes, number of falls in last month \_\_\_\_\_\_\_\_\_/ Year\_\_\_\_\_\_\_\_\_\_ | | | |
| Do You Smoke: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Regularly drink alcohol: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Please review the list below and rate those tasks that your condition affects using the scoring guide below.**  **0**=able to perform at the same level as before injury or problem (**0 1 2 3 4 5 6 7 8 9 10**) **10**=Unable to perform activity | | | |
| **Tasks** | **Score** | **Tasks** | **Score** |
| Sitting |  | Standing |  |
| Walking |  | Running |  |
| Stairs |  | Kneeling |  |
| Bending |  | Sleeping |  |
| Getting in/out of bed |  | Driving and fastening seatbelt |  |
| Housekeeping |  | Yard Work |  |
| Pulling/Pushing/Reaching/Carrying/Lifting |  | Personal Care |  |
| Coordination |  | Speaking/Reading/ Writing |  |
| Other: |  | Other: |  |

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Page 2 of 2