Integrated Physical Therapy

Subjective Report

Date_____

Name_____ Age_____ Gender: *(circle)* M F

Referring Physician_____ How did you hear about us? _____

Next Physician visit_____

THE FOLLOWING IS VERY IMPORTANT IN OUR EVALUATION PROCESS. PLEASE FILL OUT THESE FORMS AS SPECIFICALLY AS POSSIBLE TO PROVIDE US WITH A CLEAR PICTURE OF YOUR PRESENT FUNCTIONAL ABILITY AND SYMPTOMS

Occupation_____ Are you currently working? Y or N

Work Status

- □ Full Time
- □ Part Time
- □ Unemployed
- □ Restricted/light duty
- □ Retired
- □ Homemaker
- □ Student
- □ Not working because of injury

Past Medical & Family History

Please check "S" for self and/or "F" for family if you or any one in your family has or has had any of the following medical conditions, or check the "NO" box if the medical condition does not apply

□	S	□	F	□	NO	Circulatory Problems	□	S	□	F	□	NO	Tuberculosis
□	S	□	F	□	NO	GI Problems	□	S	□	F	□	NO	Stroke
□	S	□	F	□	NO	High Blood Pressure	□	S	□	F	□	NO	Kidney Disease
□	S	□	F	□	NO	Bowel/Bladder Problems	□	S	□	F	□	NO	Asthma
□	S	□	F	□	NO	Heart Problems	□	S	□	F	□	NO	Anemia
□	S	□	F	□	NO	Rheumatoid Arthritis	□	S	□	F	□	NO	Emphysema
□	S	□	F	□	NO	Pacemaker	□	S	□	F	□	NO	Depression
□	S	□	F	□	NO	Osteoarthritis	□	S	□	F	□	NO	Thyroid Problems
□	S	□	F	□	NO	Malignancy/Cancer	□	S	□	F	□	NO	Epilepsy
□	S	□	F	□	NO	Hepatits	□	S	□	F	□	NO	Diabetes

Please check all that apply if you have experienced any of the following in the past year:

- □ Severe night pain
- □ Constant pain anywhere in the body
- □ Unexplained weight loss
- □ Loss of appetite
- □ Fatigue
- □ Shortness of breath
- □ Dizziness/lightheadedness
- □ Pressure of feeling of heaviness in chest
- □ Numbness or tingling in left hand
- □ Sweating with chest pain
- □ Constant & severe pain in lower leg or arm
- □ Swelling with no history of injury
- □ Severe abdominal pain
- □ Heartburn
- □ Nausea
- □ Vomiting
- □ Change in bowel & bladder function
- □ Difficulty swallowing
- □ Blurred vision
- □ Fainting
- □ Severe headaches
- □ Sudden weakness
- □ Loss or lack of energy
- □ Pregnancy
- □ Thoughts of suicide
- □ Worrisome thoughts
- □ Loss of consciousness
- □ Uncontrolled crying or sadness

Medications & Allergies (Please *list all medications & allergies*)

Non-prescription(s): ◻ Tylenol ◻ Advil/Ibuprophen ◻ Alleve/naproxen
◻ Aspirin ◻ Vitamins/Minerals ◻ Herbal Supplements

Prescription(s): ◻ _____ ◻ _____ ◻ _____
◻ _____ ◻ _____ ◻ _____

Allergies: ◻ _____ ◻ _____ ◻ _____
◻ _____ ◻ _____ ◻ _____

Diagnostic Test/Measures: Within the past year, have you had any of the following (check all that apply)

◻ MRI ◻ CAT Scan ◻ X-Ray ◻ Bone Scan ◻ Dexa Scan
◻ EMG ◻ Angiogram ◻ Stress Test ◻ Ultrasound ◻ Other:_____

Past Medical History: Please list any surgeries, traumas, accidents or other conditions not listed above and the dates that you have throughout your life:

_____ Month/Year(/) _____ Month/Year(/)
_____ Month/Year(/) _____ Month/Year(/)

Leisure/recreational activity:

◻ walking ◻ biking ◻ hiking ◻ working out ◻ golf ◻ tennis ◻ swimming ◻ squash
◻ other_____

Please describe specifically how you injured yourself?

_____
_____
_____
_____
_____
_____

On what date did you injury/surgery occur? _____

Describe your current symptoms as a result of this injury?

_____
_____
_____

Describe or list any activities that you are currently having difficulty performing as a result of this injury?

_____
_____

Have you received the following treatment for your current condition?

Treatment	Yes	No	For how long?	Was it helpful?
Physical Therapy	◻	◻	_____	_____
Chiropractic	◻	◻	_____	_____
Acupuncture	◻	◻	_____	_____
Massage Therapy	◻	◻	_____	_____

WHAT DO YOU HOPE TO ACHIEVE THROUGH PHYSICAL THERAPY?

_____
_____
_____