Outreach Physical & Occupational Therapy
& Speech Rehabilitation, PLLC

SUBJECTIVE INFORMATION:

Name: _______________________________ Date: _____/_____/_____Age:____

Was a prescription given to the front desk? Y N

Referring Physician: Name ______________________ph#_____________________

Onset

Date of Onset/Date condition began: ________________ Onset Due to:

____

Symptoms: Primary Symptoms: ______________________Related Symptoms:

____

Pain:

Pain Frequency: _______________________

Pain Quality (type: circle :) constant intermittent Dull Sharp Other

Pain Radiation (to where): ___________________Pain Response to time of day:

____

Pain Rating:

Verbal Pain rating at present **(out of 10): 0= no pain, 10= worst pain imaginable**______/_______

Worst pain since onset: ___/___ Best pain since onset: __/___

What makes your pain better? ___________________________ Worse?

____

Is pain present at night (circle)? Yes No if yes, what position helps you to sleep? _______________

Prior Episodes of condition coming in for:

How many Episodes or Exacerbations: _____ Exacerbation Duration: _______Exacerbation Frequency:

Prior Treatment for condition (circle)? Yes No IF yes, **when** and with **what** type of practitioner: i.e.) PT., O.T, chiropractor? ____________________________

General Health Questions/Medical history

Other health Services concurrently provided for this condition:

____

Pre-existing conditions:

____

Current Medications: ____

Surgery due to condition (Circle): Yes No , If yes, date:

____

Is condition related to an auto accident? Yes No , if yes, date:

____

Is condition related to non-work accident? Yes No , if yes, date:

____

Is condition related to non-work accident? Yes No , if yes, date:

____

Have you had injections for your condition? Yes No , if yes, date:

____

Prior Falls (circle)? Yes No If yes, date: ___________

Diagnostic Tests pertinent to your symptoms (Circle) and <u>date</u>:

MRI___________ CT scan_______ X-Ray________ Other: _______________

Prior Level of function before diagnosis or injury

Prior Level of Function relating to diagnosis or current injury:

____

What activities in your daily life or work duties have been affected by your problem?

____

____

Employment History:

Are you currently working (circle)? Yes No if no, how many total days of work

Have you missed? ______

What type of work do u do? ______________________________

Are your work duties (circle)? Full Restricted how many hours per week do you work? _______

LIFESTYLE:

Are you exercising at home or on own (circle)? Yes No if yes, what type? ______________

Are you using heat or cold for condition (circle)? Yes No if yes, what type? ______________

Are you wearing a sling or brace (circle)? Yes No if yes, what type? ______________

Do you smoke (Circle)? Yes No if yes, what type? ______________

What type of non-work activities are you involved in?

____

When are you scheduled to see your Doctor again?

____

Patient Goals of Therapy, what do u want to accomplish?

What are your Functional Goals?

____

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services at Outreach Physical and Occupational Therapy and Speech Rehabilitation, PLLC.

Patient Signature: _______________________ Date: _____________________

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