LiFESTYLES physicaltherapy

# Subjective Medical History

**Name:**________________________________________ **Age**________ **Physician**_______________________________

To ensure you receive a complete and thorough initial evaluation at Lifestyles Physical Therapy, please provide us with the important background information on this form. If you do not understand a question, your therapist will assist you. Please note that all content regarding you medical history is confidential.

**Check any condition that applies:**

- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Balance of gait disturbance
- ☐ Blurred vision
- ☐ Bowel or bladder changes
- ☐ Cancer
- ☐ Chemical dependence
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema/Bronchitis
- ☐ Epilepsy
- ☐ Headaches
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Multiple Sclerosis
- ☐ Nausea
- ☐ Numbness
- ☐ Pacemaker
- ☐ Pain w/ coughing/sneezing
- ☐ Pain with deep breath
- ☐ Peptic Ulcer
- ☐ Pregnant
- ☐ Rheumatoid
- ☐ Ringing in the ears
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Weakness
- ☐ Other_____________

**Please circle the answers below that apply.**

Do you have a pacemaker? YES NO Do you smoke? YES NO (If yes ________packs a day)

Is there any chance you could be pregnant? YES NO

**Past Surgery:** Spine Knee Shoulder Hip Heart other______________

What was the date of your injury?_________________

What is the cause of your injury/illness? ______________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

**Physical Therapy Goals:**
Return to: Lying down Sitting Standing Driving Daily Living Other

**Pain Increases with:** Activity Lying Down Sitting Standing Driving Medication

**Pain decreases with:** Activity Lying Down Sitting Standing Driving Medication

**Work Status:** Light Duty Off work Normal Schedule Retired Disabled

**Please list any medications that you are taking:**______________________________________________________________________

______________________________________________________________________________________________

**What prior tests/treatment have you had for this problem?**

___X-Ray
___MRI
___CT Scan
___Bone Scan
___Arthrogram
___Physical Therapy
___Injections
___Other(please describe)___________________________________

**~Continue On Opposite Side~**

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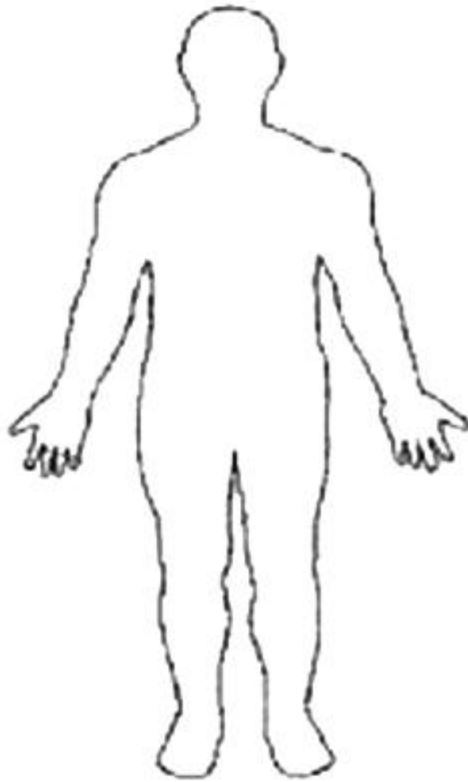
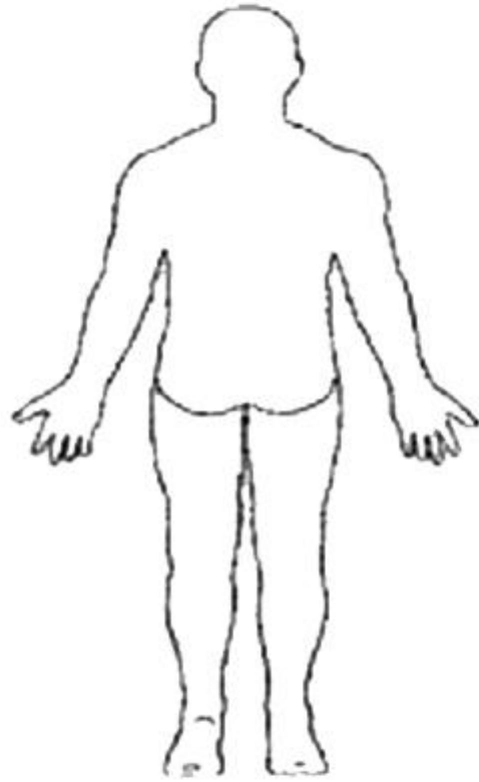
### Please indicate area of pain/numbness below

**Front**



Numbness ///
Severe Pain █

**Back**



Moderate Pain XX
Shooting Pain⇧⇩

### Current pain severity (please circle one):

None 1 2 3 4 5 6 7 8 9 10 Worst

### Is your current condition:

Getting better Getting worse Staying the same?

I understand that all medical information listed above will be kept confidential in accordance with Lifestyles Physical Therapy's Privacy Policy.

All information is true and correct to the best of my knowledge.

______________________________________________ _______________
Patients Signature Today's Date