INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET (Page 1)

Patient Name: _____ **Date of Birth:** _____ **Date of Eval:** _____

SUBJECTIVE

Age: _____ **When did your symptoms start?** _____

Hand Dominance: ☐ Right ☐ Left **Date of next Doctor's appointment:** _____

Describe the current problem that brought you here: _____

_____

Are your symptoms: ☐ Improving ☐ Getting Worse ☐ Staying the Same

Have you had any testing? ☐ X-rays ☐ MRI ☐ EMG/ Nerve Conduction Test ☐ CT Scan

☐ Other **Results:** _____

Have you ever had these symptoms before? ☐ Yes ☐ No **Description:** _____

Have you ever had treatment before for these symptoms? ☐ Yes ☐ No **If Yes, please describe:**

☐ **Medication:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

☐ **Injection:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

☐ **Physical Therapy:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

☐ **Massage/Chiropractic:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

Did you have surgery? ☐ Yes ☐ No **Date of Surgery:** _____

If yes, what procedure did you have done? _____

Have you ever purchased or rented Durable Medical Equipment, Orthotics, Prosthetics, or Supplies?

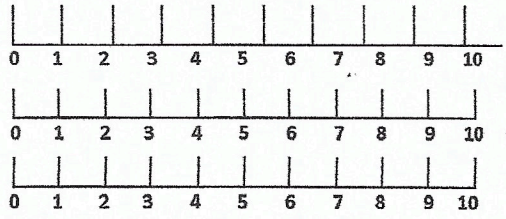
☐ Yes ☐ No **Explain:** _____

THERAPIST COMMENTS:

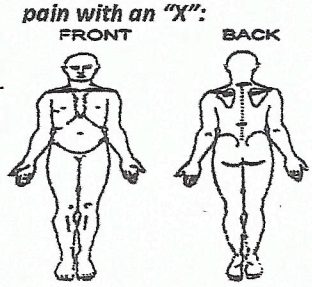
CURRENT COMPLAINTS

If you have pain, what is your pain level?

(0 = No Pain, 10 = Extreme Pain – Circle)



Mark the location of your pain with an "X":



Are your symptoms: ☐ Constant ☐ Come and Go ☐ Ache ☐ Deep ☐ Superficial ☐ Dull ☐ Sharp ☐ Shooting ☐ Burning ☐ Numbness/Tingling ☐ Other: _____

Day Pattern:

Does your pain seem to be WORSE at a certain time of day? ☐ Yes ☐ No

If Yes, ☐ Morning ☐ Night ☐ Other: _____

Does your pain progress as the day goes along? ☐ Yes ☐ No

If Yes, please explain: _____

Do you have difficulty falling asleep? ☐ Yes ☐ No **If Yes, please explain:** _____

Do you wake due to pain? ☐ Yes ☐ No **If Yes, # of times per night:** _____

THERAPIST COMMENTS:

FUNCTIONAL ABILITIES AND RESTRICTIONS

What were you doing prior to this injury that you are unable to do currently? Please list any additional activities that you are having difficulty completing. _____

☐ Squatting ☐ Sitting ☐ Driving ☐ Reaching ☐ Work Tasks ☐ Gripping/Pinching
☐ Standing ☐ Walking ☐ Lifting ☐ Dressing/Grooming ☐ Stairs ☐ Position Changes
☐ Kneeling ☐ Holding/Carrying Objects
☐ Other: _____

What activities make your pain WORSE? _____

What activities make your pain BETTER? _____

What household duties are you having difficulty performing? ☐ Cooking ☐ Cleaning ☐ Vacuuming
☐ Laundry ☐ Yard Work ☐ Grocery Shopping ☐ Other: _____

Do you use an assistive device? ☐ None ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: _____

Did you use an assistive device prior to current injury/conditions? _____

Hobbies/ Interests/ Exercise: _____

THERAPIST COMMENTS:

Patient Name: _____ Date of Birth: _____ Date of Eval: _____

WORK HISTORY/ SOCIAL HISTORY/ INTERESTS/ LIVING ENVIRONMENT

Occupation: _____ Presently Working: ☐ Yes ☐ No

If Yes, ☐ Full Duty ☐ Limited Duty: Restrictions: _____ # Days Off Work: _____

Job Duties: ☐ Sitting ☐ Computer Work ☐ Bending ☐ Heavy Lifting ☐ Traveling ☐ Standing ☐ Reaching ☐ Crawling ☐ Twisting ☐ Walking ☐ Pushing/Pulling ☐ Gripping/Pinching ☐ Other: _____

Are you now, or have you ever been disabled (service or work)? ☐ Yes ☐ No If Yes, when? _____

If Yes, please explain: _____

What is your current living arrangement? ☐ Alone ☐ Spouse ☐ Partner ☐ Family ☐ Other: _____

Does your home have stairs? ☐ Yes ☐ No If Yes, # of stairs: _____

If Yes, do your stairs have handrail? ☐ Yes ☐ No If Yes, which side going up? ☐ Right ☐ Left ☐ Both

THERAPIST COMMENTS:

PREVIOUS MEDICAL HISTORY/ MEDICAL PRECAUTIONS AND CONTRAINDICATIONS

How would you classify your general health? ☐ Good ☐ Fair ☐ Poor

In terms of your general health, please check ALL that apply:

☐ Allergies	☐ Anemia	☐ Liver/Gallbladder Problem
☐ Rheumatoid Arthritis	☐ **Recent Fever**	☐ Fibromyalgia
☐ Metal Implants	☐ **Ringing of the Ears**	☐ Asthma/Breathing Difficulties
☐ **Recent Headaches**	☐ **Recent Nausea/Vomiting**	☐ Seizures/Epilepsy
☐ **Recent Vision Changes**	☐ Heart Attack	☐ **Recent Dizziness/Fainting**
☐ Sexual Dysfunction	☐ **Cancer**	☐ **Recent Change in Bowel/Bladder Habits**
☐ Osteoarthritis	☐ Skin Abnormalities	☐ **Pain with Cough/Sneeze**
☐ Heart Palpitations	☐ Osteoporosis	☐ Smoking History
☐ Chest Pain/Angina	☐ Hernia	☐ Pacemaker
☐ Stroke/TIA	☐ Depression	☐ High/Low Blood Pressure
☐ Physical Abnormalities	☐ Surgeries	☐ Diabetes I or II
☐ Hypoglycemia	☐ Polio	☐ **Unexplained Weight Loss/Gain**
☐ **Night Pain**	☐ Intolerance to Cold/Heat	☐ Pregnancy (Currently)
☐ Urine Leakage	☐ Recent Fractures	☐ **Recent Unexplained Fatigue**
☐ Kidney Problems	☐ Heart Disease	☐ **Numbness/Tingling in Hip/Buttocks Area**

Is there any other information regarding your medical history or are there any factors that may complicate your ability to participate in therapy that we should know about? _____

_____

_____

Have you had any falls in the past 12 months? ☐ Yes ☐ No If Yes, how many times? _____

If Yes, please describe the nature of the fall (s): _____

If Yes, please describe if an injury(ies) occurred: _____

_____

THERAPIST COMMENTS:
☐ See Attached List

MEDICATIONS

Please list all of the medications [*with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)*] that you are currently taking [including over-the-counter, prescriptions, herbals, and vitamins/mineral(s)]:

_____

_____

_____

THERAPIST COMMENTS:
☐ See Attached List

PATIENT GOALS FOR THERAPY

What are your goals for participating in Therapy? (I.E: performing household tasks without pain)

_____

_____

THERAPIST COMMENTS:

SIGNATURES

To the best of my knowledge I have fully informed you of the history of my problem and current status.

Patient's Signature: _____ Date: _____

Therapist's Signature: _____ License #: _____ Date: _____

Printed Therapist's Name: _____

CANCELLATION AND NO-SHOW POLICY

Although we understand emergency situations do arise, if you need to cancel or change an appointment time, kindly give 24 hours notice in order to avoid payment for the session. Failure to do so will result in a $50 fee. By signing below, you acknowledge understanding of this policy.

Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES

I read or was offered a copy of the NOTICE OF PRIVACY PRACTICES.

Signature_____ Date_____

CONTACT PERMISSION

I authorize the release of appointment information left on the voicemail or message center at:

Home phone number_____ Work phone number_____

Cell phone number _____ Email_____

____ Send me text message reminders before my appointments

____ It's OK to send me a Perform Physical Therapy newsletter to my email address

RELEASE AND INDEMNITY AGREEMENT

I warrant that I have read the CONSENT TO TREAT document , either the copy offered to me or on display in the clinic, and know its contents, and that I have executed this document voluntarily and as my own free act. I execute this document fully intending to be bound by its terms. This agreement shall be governed and construed in accordance with the laws of the commonwealth of Illinois, without regard to principles of conflict laws. Executed to be effective as of the date set forth below.

Signature (patient or guardian) _____ Date_____

ASSIGNMENTS OF BENEFITS

I hereby instruct and direct the below-named insurance to pay by check made out to the healthcare provider identified and mailed to the corresponding address. If my current policy prohibits direct payment for the professional or medical expense benefits allowable, otherwise payable to me under my current insurances/ early intervention policy as payment toward the total charges for the professional services rendered. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance, of said professional service charges over and above this insurance payment. I hereby authorize:

☐A photocopy of this Assignment shall be considered as effective and valid as the original

☐The release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

☐The use of this signature on all insurance submissions.

☐The "Healthcare Provider" named above to deposit checks in my name.

☐The "Healthcare Provider" named above to initiate a complaint to the insurance Commissioner for any reason on my behalf.

☐That I am financially responsible for all changes whether or not paid by insurance..

Signature (patient or guardian)_____ Date_____

Name of insured family member_____ Insured's date of birth_____