EMORY CLINIC
Physical Therapy

MEDICAL HISTORY / SUBJECTIVE INFORMATION

Name:_____ Date:____/____/____ Birthdate: ____/____/____ Age:_____

Referring Physician:_____ Phone #: _____ Height: _____ Weight: _____
Diagnosis: _____

Medical History: **(Please check all that apply)**

____ Heart Disease	____ Diabetes	____ High Blood Pressure	____Pacemaker
____ Cancer	____ Tuberculosis	____ Visual Impaired	____ Epilepsy
____ HIV /AIDS	____ Arthritis	____ Hearing Impaired	____ Fibromyalgia
____ Stroke	____ Asthma	____ Latex Allergy	____ Scoliosis
____ Osteoporosis	____ Hepatitis	____ Allergies	____ Headaches
____ Chest Pain	____ Kidney Problems	____ Pregnant	____ Seizures
____ Metal Implants	____ Dizziness	____ Fractures	____ Ear Ringing

Therapist's comments: _____

_____

Have you had surgery for your condition? Y N If yes, please give approximate date:_____

Have you had any injections for your condition? Y N If yes, please give approximate date:_____

Please list any diagnostic tests you have had for this condition: _____

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

What are your current symptoms?_____

How the injury or problem occur?_____

Please rate your pain using a 0 – 10 scale (0 = no pain, 10 = the worst pain you can imagine)
Worst pain since onset:_____ **Best** pain since onset:_____ **Today's** pain:_____

Where is your pain or problem located?_____

Is your pain? Constant Intermittent

What makes your pain / problem **better**?_____ **Worse**?_____

Is there pain present at night? Y N What position helps you to sleep? _____

Therapist's Comments:_____

_____

Employment History:
Are you currently working? Y N If no, how many total days of work have you missed?_____

Are your work duties? Full Restricted How many hours per week do you work?_____

Who is your employer?_____

What type of work do you do?_____

What critical work duties have been most affected by your problem?_____

What do you hope to accomplish with therapy?_____

_____

PLEASE RATE YOUR ABILITIES USING THE FOLLOWING SCALE:

1 = CAN DO WITHOUT DIFFICULTY **3 = CAN DO WITH GREAT DIFFICULTY**

2 = CAN DO WITH SOME DIFFICULTY **4 = CAN'T DO AT ALL**

					Comments: **Therapist use only**
Lying down	1	2	3	4	
Sitting	1	2	3	4	_____
Standing	1	2	3	4	
Walking	1	2	3	4	_____
Jogging/running	1	2	3	4	
Going up stairs	1	2	3	4	_____
Going down stairs	1	2	3	4	
Lifting/carrying	1	2	3	4	_____
Driving a car	1	2	3	4	
Overhead reaching	1	2	3	4	_____
Housework	1	2	3	4	
Yardwork	1	2	3	4	_____
Dressing	1	2	3	4	
Sexual activity	1	2	3	4	_____

Are you exercising at home? Y N If yes, what type?_____

Are you using heat or cold? Y N If yes, what type?_____

Are you wearing a sling or brace? Y N If yes, what type?_____

Do you smoke? Y N If yes, how much?_____

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

When are you scheduled to see your doctor again?_____ .

Therapist's comments:_____

_____

Therapist Signature:_____

To the best of my knowledge and belief, the information I have given is complete and true. I hearby give my consent to receive therapy services at _____.

I have received a copy of The Patient/Client Rights and Responsibilities Information Sheet.

Patient Signature:_____

Legal Guardian Signature (If patient is a minor):_____

Date: _____