

# Subjective Report/PMHX Form

LABEL \_\_\_\_\_

Date: \_\_\_\_\_

Please answer the following questions pertaining to your CURRENT medical condition:

Therapist Comments:

## SUBJECTIVE HISTORY:

What is your date of injury/onset of symptoms? \_\_\_\_\_

How did you injure yourself? \_\_\_\_\_

Have you had any of the following?  X-rays  CT scan  MRI  EMG/Nerve Conduction Test  
 Other \_\_\_\_\_ When is your next Doctor's visit? \_\_\_\_\_

Have you had any prior occurrences of this condition?  Yes  No  
If yes, explain \_\_\_\_\_

Have you had any prior treatment for this injury?  Yes  No  
If yes, explain \_\_\_\_\_

Due to your current physical ailment, do you feel a need for or want a social worker to contact you?  
 Yes  No

## CURRENT COMPLAINTS:

What is your chief complaint? \_\_\_\_\_

What makes your pain BETTER? \_\_\_\_\_

What makes your pain WORSE? \_\_\_\_\_

## FUNCTIONAL/ADL ABILITY RESTRICTIONS:

PLEASE COMPLETE ATTACHED FUNCTIONAL QUESTIONNAIRE

## PRIOR LEVEL OF FUNCTION:

How were you functioning on a daily basis prior to your injury? \_\_\_\_\_

## PAIN RATING:

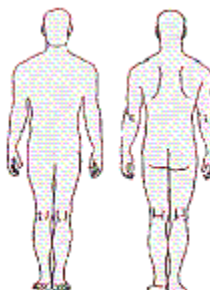
If you have pain, what is your pain level?  
(0 = No Pain, 10 = Extreme Pain)

Mark the location of your pain with an X:

CURRENT Pain Level: (Circle)  
0 1 2 3 4 5 6 7 8 9 10

Pain Level at BEST: (Circle)  
0 1 2 3 4 5 6 7 8 9 10

Pain Level at WORST: (Circle)  
0 1 2 3 4 5 6 7 8 9 10



## OCCUPATION/WORK STATUS:

What is your occupation? \_\_\_\_\_ Are you presently working?  Yes  No

If yes,  Full  Limited Duty Explain: \_\_\_\_\_

Are you now, or ever have been disabled (service at work)?  Yes  No

If yes, when? \_\_\_\_\_

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LABEL \_\_\_\_\_

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Please answer the following questions pertaining to your CURRENT medical condition:

Therapist Comments:

## SOCIAL HISTORY/INTERESTS/LIVING ENVIRONMENT:

Do you live:  Alone  With spouse  With family  Other \_\_\_\_\_

Do you have stairs?  Yes  No If yes, how many? \_\_\_\_\_ Do stairs have handrail?  Yes  No

How are your interests/hobbies affected by your symptoms? \_\_\_\_\_

## PREVIOUS MEDICAL HISTORY/GENERAL HEALTH/PRIOR HOSPITALIZATIONS:

Do you have, or have you ever had any of the following?

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Allergies                     | <input type="checkbox"/> Fibromyalgia             | <input type="checkbox"/> Liver/Gallbladder Problem | <input type="checkbox"/> Recent Fractures     |
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Metal Implants            | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma/Breathing Difficulties | <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Nausea/Vomiting           | <input type="checkbox"/> Ringing of the Ears  |
| <input type="checkbox"/> Bowel/Bladder Abnormalities   | <input type="checkbox"/> Heart Disease            | <input type="checkbox"/> Night Pain                | <input type="checkbox"/> Seizures/Epilepsy    |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Heart Palpitations       | <input type="checkbox"/> Osteoarthritis            | <input type="checkbox"/> Sexual Dysfunction   |
| <input type="checkbox"/> Chest Pain/Angina             | <input type="checkbox"/> Hernia                   | <input type="checkbox"/> Osteoporosis              | <input type="checkbox"/> Skin Abnormalities   |
| <input type="checkbox"/> Depression                    | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Pacemaker                 | <input type="checkbox"/> Smoking History      |
| <input type="checkbox"/> Diabetes I or II              | <input type="checkbox"/> Hypoglycemia             | <input type="checkbox"/> Physical Abnormalities    | <input type="checkbox"/> Stroke/TIA           |
| <input type="checkbox"/> Dizziness/Fainting            | <input type="checkbox"/> Intolerance to Cold/Heat | <input type="checkbox"/> Polio                     | <input type="checkbox"/> Surgeries            |
| <input type="checkbox"/> Fever                         | <input type="checkbox"/> Kidney Problems          | <input type="checkbox"/> Pregnancy (Currently)     | <input type="checkbox"/> Urine Leakage        |

Is there any other information regarding your medical history that we should know about? \_\_\_\_\_

## STATEMENT OF SELF-RELATED HEALTH

How would you classify your general health?  Good  Fair  Poor

## MEDICAL PRECAUTIONS/CONTRAINDICATIONS:

Are there any factors that may complicate your ability to participate in therapy?  Yes  No

If yes, please explain: \_\_\_\_\_

Have you fallen in the past 12 months?  Yes  No If yes, how many times? \_\_\_\_\_

If yes, please describe the nature of the fall(s) and if an injury(ies) occurred: \_\_\_\_\_

## MEDICATIONS:

Please list all of the medications that you are currently taking: \_\_\_\_\_

## PATIENT'S GOALS FOR PHYSICAL THERAPY/OT:

What are your goals for participating in therapy? \_\_\_\_\_

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

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_

Date: \_\_\_\_\_