Advance Physical Therapy Services

Patient Medical History/Subjective Summary

Patient Name: _____ Date of Birth: _____

Occupation: _____

Daily Activities at Work: _____

Daily Activities at Home: _____

Hobbies: _____

Briefly give a history of your injury – Why are you here?

_____

_____

_____

Past medical history: (Please list past injuries, conditions, accidents, traumas).

_____

_____

_____

List previous surgeries and dates: _____

_____

_____

Have you had any of the following for this condition: _____X-Ray, _____MRI, _____EMG, _____Other: _____.

If so, are you aware of the results of these tests? Explain: _____

_____

Have you had treatment for this condition before? Yes_____ No _____

If yes, **when** and **where** did you receive treatment? _____

_____

Do you have any known allergies? _____ Yes _____ No

If yes, please describe: _____

Do you have any of the following medical conditions? Circle all that apply:

Arthritis	Dizziness	Diabetes Mellitus	Cancer
Rheumatoid Arthritis	Seizure's/Epilepsy	Weight loss/gain > 20 lbs	Metal Implants
Pacemaker	Asthma	Visual Disturbances	Heart Trouble/CAD
Current Pregnancy	High Blood Pressure	Headaches	History Of Falls

OTHERS: _____

Do you exercise regularly? _____Yes _____No

If yes, what do you do and how often? _____

_____

What are your goals for Physical Therapy?

_____

_____

Please indicate the amount of pain you are experiencing with your current condition:

0 1 2 3 4 5 6 7 8 9 10

Please shade in areas of pain on the diagram below:

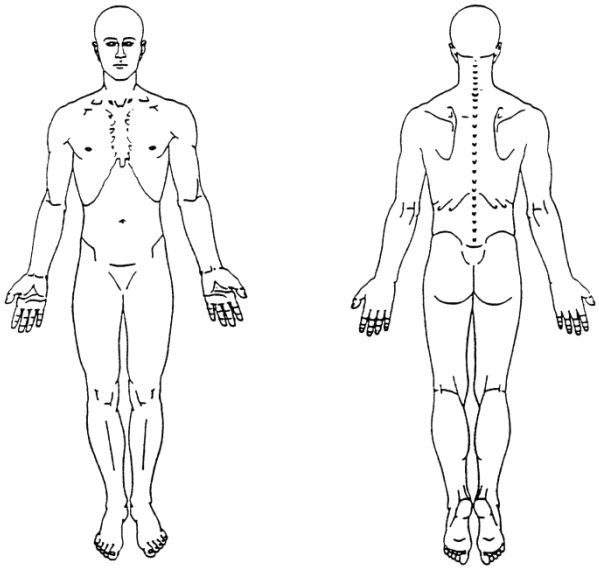
Key:

Numbness: ======

Pins/Needles: oooo

Burning Pain: xxxxxx

Stabbing Pain: //////



Patient Signature: _____DOB: _____

Therapist Signature: _____ Date: _____