FUSION ARTS PHYSICAL THERAPY - SUBJECTIVE INFORMATION SHEET

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. Thank you!

NAME: ____ **DOB**: ___________ **AGE**: _____
OCCUPATION: _______________________________ **HEIGHT:** ________**WEIGHT:** ____________
DATE OF INJURY/ONSET: _____________________ **DATE OF SURGERY:** _________________
HOBBIES/LEISURE ACTIVITIES:

____

____

____

Are you currently seeing any of the following?

A. Medical Doctor	Yes	No
B. Acupuncturist	Yes	No
C. Chiropractor	Yes	No
D. Osteopath	Yes	No
E. Physical Therapist	Yes	No
F. Psychiatrist/Psychologist	Yes	No

If you have been seen by any of the above during the past six months, please describe for what reason:

____

____

Have you had any diagnostic studies? If so, please provide date: _______________________________

______ X-ray _____ MRI _____ Doppler
_____ CT Scan _____ Ultrasound

Do you have now, or have you had any of the following conditions?

_____ Allergies/skin sensitivity
_____ Alzheimer's or memory deficits
_____ Anemia
_____ Asthma or other breathing difficulties
_____ Cancer: Location _____________________
_____ Cauda Equina Syndrome
_____ Cerebral Vascular Accident
_____ Circulation problems/clots
_____ Chemical Dependency (i.e. alcoholism)
_____ Current Infection
_____ Depression
_____ Diabetes – Type I or Type II
_____ Fibromyalgia
_____ Fracture or suspected fracture
_____ Heart Problems
_____ Hepatitis
_____ High or low Blood Pressure
_____ High Cholesterol
_____ Huntington's
_____ Immunosuppression
_____ Lupus
_____ Obesity
_____ Osteoarthritis
_____ Osteoporosis/ Osteopenia
_____ Parkinson's Disease
_____ Rheumatoid Arthritis
_____ Thyroid Problems
_____ Traumatic Brain Injury
_____ Tuberculosis
_____ Other

If you checked any of the conditions please explain (date, region of body, current treatments):

____

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____

Have you fallen in the past 12 months? _____ If so, please explain (i.e. wet floor, caught edge rug)

____

____

Have you recently noted any of the following?

_____ Weight gain/loss _____ Numbness/tingling _____ Urinary frequency changes
_____ Dizziness _____ Weakness _____ Headaches
_____ Nausea/Vomiting _____ Fever/Chills/Sweats _____ Fatigue _____Pain at night

Please list any PRESCRIPTION MEDICATION that you are currently taking, along with dosage and frequency:

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____

____

____

Please list any OVER-THE-COUNTER medications that you have taken in the past week?

_____Aspirin _____Laxatives _____Antacids
_____Tylenol _____Decongestants
_____ Advil/Motrin/Ibuprofen _____Antihistamines

Please list any vitamins, herbs or homeopathic remedies that you are currently taking:

____

Do you have any allergies to medications? If so, please list.

____

Please list any surgeries or other conditions for which you have been hospitalized (including the date):

____

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____

____

Please list any injuries for which you have been treated (including the date):

____

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Do you smoke? If so, how many packs of cigarettes do you smoke a day? ____________________________

How many caffeinated beverages do you drink per day (i.e. soda, coffee, tea)? ________________________

What are your expectations with physical therapy (i.e. goals, outcome)?

____

____

____

Patient's Signature ____ **Date:** ___________________

Is your pain constant (24-hours per day) or intermittent?

____

Describe your pain?

_____ Aching _____ Burning _____ Throbbing
_____ Numbness _____ Tingling _____ Sharp
Other Description: ____

Describe the location of your pain?

____
____

What is the intensity of your pain on a 0 - 10 scale (10 is the highest level of pain)?

At its worst? _______________________

Currently? _________________________

At its best__________________________

What activities aggravate your pain?
If standing, walking or sitting, describe the time frame before the onset of pain –(i.e. 30 minutes, 15 minutes)

____
____

What activities ease your pain?

____
____

Is there a pattern to your pain? Better or worse in the morning? Mid-day or evening? Better when?

____
____
____
____
____

Who referred you to us? Friend? Colleague? Provider? Already a Former Patient here?

____

Additional Information? ____
____
____
____
____