

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

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

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:

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):

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

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: _____