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):
_____
_____
_____

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: _____