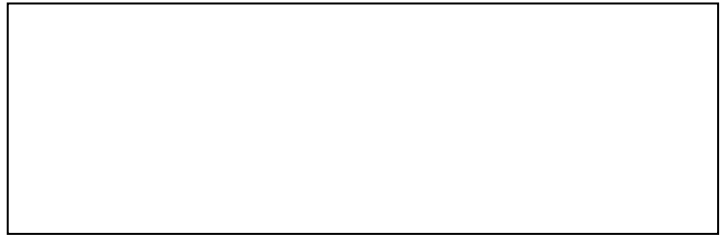


- Maplewood Phone: 651/ 232-7820 Fax: 651/ 232-7832
- Oakdale Phone: 651/ 232-5075 Fax: 651/ 232-5085
- University Park/Midway Phone: 651/ 232-5412 Fax: 651/ 232-4971
- Woodwinds/Woodbury Phone: 651/ 232-6767 Fax: 651/ 232-6766



**PATIENT'S MEDICAL HISTORY/SUBJECTIVE INFORMATION**

Name you prefer: \_\_\_\_\_  Male  Female  
 Occupation: \_\_\_\_\_ hrs/week \_\_\_\_\_  Retired (last time worked \_\_\_\_\_)  
 Positions required/tasks you perform at work: \_\_\_\_\_

Leisure activities/Exercise: \_\_\_\_\_  
 Right handed  Left handed

How do you best learn?  Listening  Pictures  Watching  Reading  Performing  
 Please list any allergies: \_\_\_\_\_  None

Sensitivities:(circle if any) Elastic Latex Tape or NONE?  
 Have you been diagnosed with any of the following:  None

<input type="checkbox"/> Metal Implant: Location _____	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Arthritis: _____	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Heart Problems: _____	<input type="checkbox"/> Chemical Dependence	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Cancer : _____	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Stroke
<input type="checkbox"/> Breathing problems: _____	<input type="checkbox"/> Blood clots/Circulation	<input type="checkbox"/> Depression
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Other _____
<input type="checkbox"/> Infectious Disease (AIDS, HIV, TB)		

**FOR WOMEN:** Are you currently pregnant or think you might be pregnant?  Yes  No

Current Medications: (include purpose)  None      Surgery, Injections, or Other Procedures:  None

_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____

Have you had any diagnostic tests performed for your problem?  X-ray  MRI  Other \_\_\_\_\_  
 Date? \_\_\_\_\_ Results? \_\_\_\_\_

Date of next MD visit (Primary and/or Referring)? \_\_\_\_\_

Do you eat a well balanced diet?  Yes  No      Do you smoke?  Yes  No

Any unexplained weight loss or gain?  Yes  No

Do you have problems with dizziness or balance  YES  NO Have you fallen in the last 6 months?  Y  N  
 If yes, please describe: \_\_\_\_\_

In the past year, have you been the victim of abuse (physical, emotional, sexual, or financial)?  YES  NO

What are your goals for coming to therapy? \_\_\_\_\_



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**Additional Subjective Information**

When did your symptoms start? (Please give month/year)

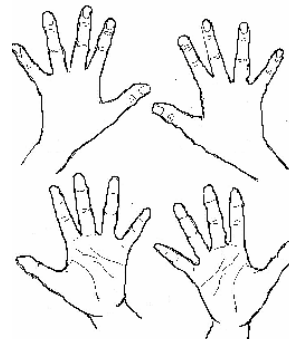
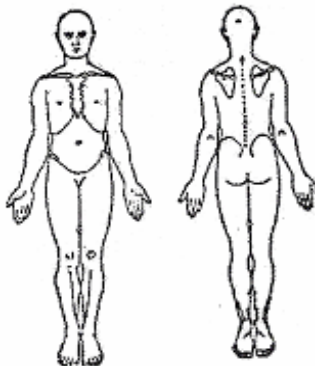
Was there an injury? Yes No

Explain: \_\_\_\_\_

**Rate your symptoms/pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)**

**Now/Today:** \_\_\_\_\_ **At your worst:** \_\_\_\_\_ **At your best:** \_\_\_\_\_

Mark an "X" for pain



Describe symptoms/pain: \_\_\_\_\_

Are there things that you can do to relieve your symptoms?  No  Yes List: \_\_\_\_\_

Does your pain wake you up at night?  Yes  No How many times? \_\_\_\_\_/night

Please indicate how long you are able to do each activity before the symptoms appear OR get worse:

Stand \_\_\_\_\_ min. / hours Sit \_\_\_\_\_ min. / hours Walk \_\_\_\_\_ min. / hours

Mark the activities that are difficult for you to do because of your condition.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Get in/out of bed/chair/car | <input type="checkbox"/> Reach into cupboard  | <input type="checkbox"/> Carry laundry/groceries |
| <input type="checkbox"/> Change sleeping positions   | <input type="checkbox"/> Groom/dress          | <input type="checkbox"/> Dependent Care          |
| <input type="checkbox"/> Bend                        | <input type="checkbox"/> Kneel/squat          | <input type="checkbox"/> Look up/down/turn head  |
| <input type="checkbox"/> Up/down steps               | <input type="checkbox"/> Yard work/House work | <input type="checkbox"/> Type/write              |
| <input type="checkbox"/> Walk on uneven surfaces     | <input type="checkbox"/> Wash/bath/shower     | <input type="checkbox"/> Grip/hold object        |
| <input type="checkbox"/> Lift                        | <input type="checkbox"/> Meal preparation     | <input type="checkbox"/> Chew/yawn               |
| <input type="checkbox"/> Other _____                 |   |  |

**PATIENT SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient consent:** I agree with the treatment plan of care.  YES  NO \_\_\_\_\_ (patient initials)

**To be completed by therapist:**

**Abuse:**  No  Yes **Refer to Social Services** \_\_\_\_\_

**Falls: Is patient at risk?**  Yes  NO; **Assessment Completed:**  Tinnetti  Berg  Timed Sit to Stand

**THERAPIST'S NOTES:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Therapist Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_