SUMMIT REHABILITATION

MEDICAL HISTORY/SUBJECTIVE INFORMATION

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Your Name:				**Today's Date:**
Date of Birth:	**Age:**	**Height:**	**Weight:**	**Do You Smoke?** ☐ **Yes** ☐ **No**
Sex: ☐ **Male** ☐ **Female** **If female,** are you currently pregnant? ☐ **No** ☐ **Yes** **If yes,** ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester				

Have you ever been diagnosed with any of the following?

Tuberculosis	☐ No	☐ Yes	Cancer	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Heart Condition	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes	Respiratory Problems	☐ No	☐ Yes

Other:____

Who referred you to physical therapy? ______________________________

Primary Physician ______________________________

Tell Us About Your Condition

When did you first notice the pain or have functional problems due to the condition/injury? (Please provide approximate dates): ______________________________

Recent flare-up? ☐ No ☐ Yes If yes, when ______________________________

What activities are limited by this condition? (e.g. lift, reach):______________________________

How did your injury/symptoms occur? ______________________________

____

What do you expect to accomplish with physical therapy? ______________________________

Are your symptoms: ☐ Constant? ☐ Intermittent? ☐ Getting Better?
☐ Getting worse? ☐ Staying the same?

What makes your symptoms better? ______________________________

0-10 pain scale (0 = No Pain; 5= Moderate Pain; 10 = The Most Extreme Pain)

Worst pain rating: 0 1 2 3 4 5 6 7 8 9 10

Best pain rating: 0 1 2 3 4 5 6 7 8 9 10

For this injury, has your medical care included: (check those that apply)

☐ Surgery: When? ___/___/___ What kind?____________________

☐ Injection: When? ___/___/___ Did it help? ☐ Yes ☐ No

☐ Other treatment:

- ☐ Physical therapy If yes, when? ___/___/___to ___/___/__
  What was done?______________________________
- ☐ Chiropractor If yes, when? ___/___/___to ___/___/___
  What was done? ______________________________
- ☐ Medications: ______________________________
- ☐ X-ray ____________________ ☐ MRI ____________________
- ☐ CT scan ____________________ ☐ Other: ____________________
- ☐ Exercises: What kind? ______________________________

Indicate on body diagrams **where** your symptoms are located

■ = Pain ***III*** = Numbness

Comments:____

____

____

Effective: January 2013

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Work Information

Who is your employer? ___

What is your job title/responsibilities? ___

Are you currently working? ☐ No ☐ Yes If yes, numbers of hours per week ___

☐ Full Duty ☐ Restricted Duty

How many total work days have you missed? ___ Do you have a case manager/QRC? ☐ No ☐ Yes

Your Therapist Will Complete This Section

Critical work, ADL, or leisure activities affected: ___

- Lift/carry: ☐ ≤ 20 lbs. rarely to occasionally (**low demand**)
  ☐ > 20 lbs., or > 1lb. constantly or > 10 lb. frequently (**mod-high demand**)
  Where to where ___ to ___.
- Repetitive motions related to condition: ☐ Occasional 1-33% (**low demand**)
  ☐ Frequent to Constant 34-100% (**mod-high demand**)
- Static positions related to condition (**mod-high**): ☐ Sit ☐ Stand ☐ Crouch
  ☐ Kneel ☐ Overhead work ☐ ___
- Leisure Activities: ☐ None/minimally impact condition **(low demand)**
  ☐ Moderate-high intensity, competitive **(mod-high demand)**

Overall functional demand (work/ADL/leisure) ☐ Low Demand ☐ Moderate-High Demand

Comments: ___

Additional Comments:___

Indicate either "Yes" or " No" as to whether each of the following activities is difficult.

Activity	Difficult?	Activity	Difficult?
Drinking or Eating	☐ Yes ☐ No	Balancing on both feet	☐ Yes ☐ No
Sleeping Through the Night	☐ Yes ☐ No	Walking on: stairs, flat surfaces, inclines, uneven surfaces, ladders	☐ Ye ☐ No
Dressing: Putting on or taking off shoes, socks, shirt, jacket or pants	☐ Yes ☐ No	Lifting	☐ Yes ☐ No
Maintaining static position of; Head bent forward, arms overhead, arms forward, or turning head	☐ Yes ☐ No	Carrying	☐ Yes ☐ No
Getting in/out of: chairs, bed, car or bath/shower	☐ Yes ☐ No	Bending, Kneeling Squatting	☐ Yes ☐ No
Reaching: overhead, behind back, downward for forward	☐ Yes ☐ No	Driving a vehicle or ability to use gas/brake pedals	☐ Yes ☐ No
Gripping, Holding tools or Opening Jars	☐ Yes ☐ No	Caring for child or adult	☐ Yes ☐ No
Picking up Small Objects	☐ Yes ☐ No	Housework / Yard work	☐ Yes ☐ No
Sitting	☐ Yes ☐ No	Recreational Activities	☐ Yes ☐ No
Standing	☐ Yes ☐ No	Have you fallen more than 1 time in the past year	☐ Yes ☐ No
Job Related Activities	☐ Yes ☐ No	Have you fallen and hurt yourself in the past year	☐ Yes ☐ No

Other: