Subjective Medical History

Name_____ **Preferred Name**_____ **Age**_____
Pronouns_____

Referring provider:_____

Primary care physician:_____

How did you hear about us: □**Physician** □**Friend/family** □**Web** □**Return Patient** □**Other:**_____

Check any condition that applies:

□Allergies_____	□Depression	□Unexpected weight loss/gain	□High blood pressure
□Anemia	□Diabetes	□Kidney disease	□Pregnant
□Arthritis_____	□Dizziness	□Multiple Sclerosis	□Rheumatoid
□Asthma	□Emphysema/Bronchitis	□Nausea/vomiting	□Ringing in ears
□Balance or gait disturbance	□Epilepsy	□Numbness	□Stroke
□Blurred vision	□Fibromyalgia	□Pacemaker	□Thyroid problems
□Bowel or bladder changes	□Headaches	□Parkinsons	□Tuberculosis
□Cancer_____	□Heart problems	□Pain with coughing/sneezing	□Weakness
□Chemical dependency	□Hepatitis	□Pain with deep breath	□Other: _____

Please list any past surgeries:_____

_____

Regarding today's visit:

What was the date of your injury/onset of symptoms? _____ **Please provide a brief history:**

_____

_____

Have you received any treatment for this condition? yes/no ***If yes, please provide more information below***

_____

Physical Therapy goals: _____

Pain Increases with: _____

Pain Decreases with: _____

Occupation/Duties: _____

Current Work Status: □Light Duty □Off Work □Normal Schedule □Retired □Disabled

Please list any medications you are taking:_____

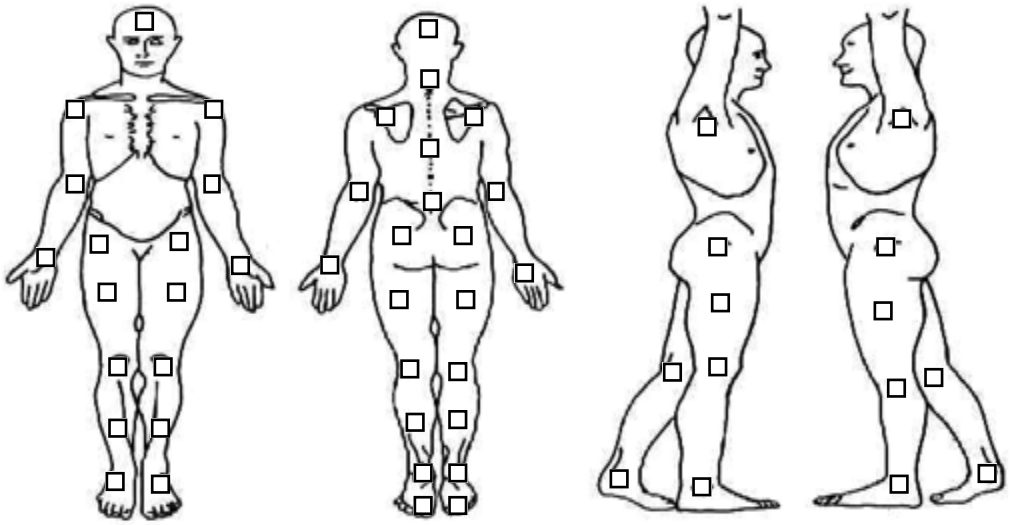
What prior tests/treatment have you had for *this* problem?

□X-Ray	□Arthrogram	□Bone Scan
□MRI	□Physical Therapy	□Other (please describe)
□CT Scan	□Injections	_____

Please continue on other side ☞

Please indicate problem areas below

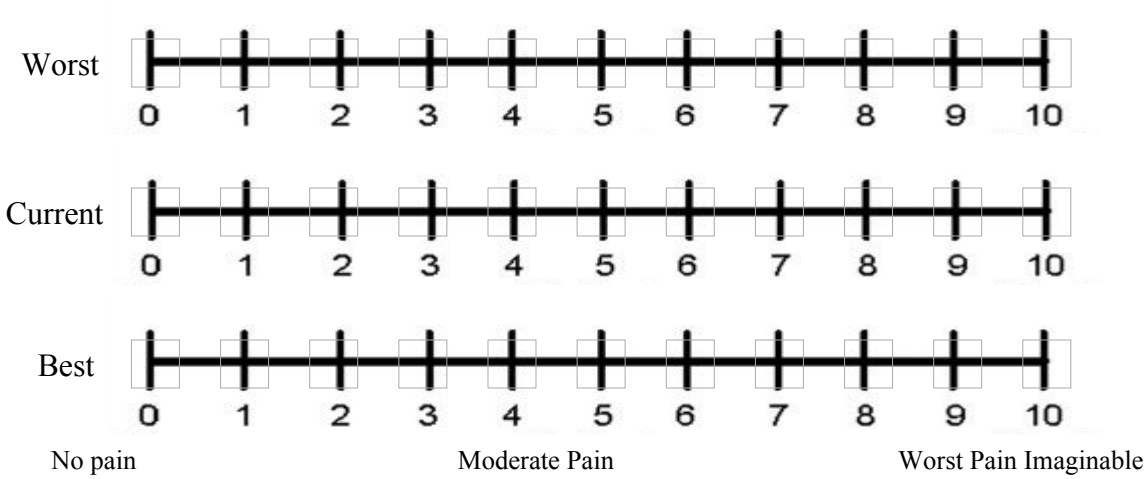
Please use the body chart below to indicate the quality and location of your symptoms



Check all that apply:

☐Sharp	☐Throbbing	☐Stabbing	☐Cramping
☐Dull/Achy	☐Shooting	☐Clicking/Popping	☐Spasms
☐Numbness/Tingling	☐Worse in AM/PM	☐Stiff/Sore	☐Hot
☐Swollen	☐Better in AM/PM	☐Intermittent	☐Constant

Please rate your level of pain at **worst**, **current**, and **best**. Do so using 3 circles:



My current condition is:

☐Getting **better** ☐Getting **worse** ☐Staying the **same**

I understand that all medical information listed above will be kept confidential in accordance with Mitchell Physical Therapy's Privacy Policy. All information is true and correct to the best of my knowledge.

Patient Signature_____ **Today's Date**_____