PATIENT MEDICAL HISTORY AND SUBJECTIVE INFORMATION

Name:_________________________________Date:____/____/____ Birthdate: ____/____/____ Age:_____
Sex: M F Referring Physician:________________________ Phone #: __________________________
Diagnosis: ____
Primary Language: ___________________________
Preferred learning style: (please circle) Reading Hearing Seeing Doing Other _________________
Level of formal education: (please circle) None Grade/Middle School High School College
Factors/Barriers that may effect teaching/learning process (If Yes, describe in space provided)

- Cultural/religious practices No Yes____
- Psychosocial or emotional No Yes____
- Physical limitations No Yes____
- Cognitive Factors No Yes____
- Financial implications or needs No Yes____

Who other than the patient will be involved in the education process? (specify)______________________________

Medical History: **(Please check all that apply)**

____ Heart Disease ____ Diabetes ____ High Blood Pressure ____Pacemaker
____ Cancer ____ Epilepsy ____ HIV /AIDS ____ Arthritis
____ Hearing/Visual Impaired ____ Stroke ____ Asthma
____ Latex Allergy ____ Osteoporosis ____ Hepatitis ____ Kidney/Bladder Control
____ Dizziness

TB Screening

Recent history of persistent cough Yes No Recent history of persistent fever Yes No
Recent history of night sweats Yes No History of treatment or exposure to TB Yes No
Recent history of weight loss Yes No

Have you had any operations? Yes No If yes, please list____
____
Please list all **medications** that you are taking: ____
____
Are you allergic to anything? ____

If you are female, is there any possibility that you are pregnant? Yes No

How the injury or problem occurred and when (date) ? ____
____
Have you any prior/previous treatments? Y N X-rays MRI CAT SCAN Injections Chiropractic Therapy
Where is your pain or problem located?____
Is your pain? Constant Intermittent
Please rate your pain using a 0 – 10 scale (0 = no pain, 10 = the worst pain you can imagine)
Worst pain since onset:_________ **Best** pain since onset:___________ **Today's** pain:______________
Does the pain wake you at night? Y N What position helps you to sleep?___________________________
What makes your pain / problem **better?** ____________________________**Worse**?________________________
Therapist's Comments:____
____
____
____
____

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Employment History:
Are you currently working? Y N If no, how many total days of work have you missed?__________
Are your work duties? Full Restricted How many hours per week do you work? ____________________
Who is your employer? ____
What type of work do you do? ____
What critical work duties or activities have been most affected by your problem? ____________________________
____

What do you hope to accomplish with therapy? ____
____

PLEASE RATE YOUR ABILITIES USING THE FOLLOWING SCALE:

1 = CAN DO WITHOUT DIFFICULTY **3 = CAN DO WITH GREAT DIFFICULTY**
2 = CAN DO WITH SOME DIFFICULTY **4 = CAN'T DO AT ALL**

					Comments: **Therapist use only**
Lying down	1	2	3	4	
Sitting	1	2	3	4	______________________
Standing	1	2	3	4	
Walking	1	2	3	4	______________________
Jogging/running	1	2	3	4	
Going up/down stair	1	2	3	4	______________________
Lifting/carrying	1	2	3	4	
Driving a car	1	2	3	4	______________________
Overhead reaching	1	2	3	4	
House/Yard work	1	2	3	4	______________________
Dressing	1	2	3	4	

Are you exercising at home? Y N If yes, what type? ____________________
Are you using heat or cold? Y N If yes, what type? ____________________
Are you wearing a sling or brace? Y N If yes, what type? ____________________

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services from Rehab Services of Houston.
I have received a copy of The Patient/Client Rights and Responsibilities Information Sheet.

Patient Signature:______________________________

Date: ____________________

Therapist Section

Identified needs for community resources: Child/Youth Senior Adult Support Groups
Plans to address special learning factors/barriers (as identified)______________________________
____

Therapist Signature:________________________ Date: ________________________