Patient Medical History/Subjective Summary

Patient Name: ____ Date of Birth: __________________________

Occupation: ____

Daily Activities at Work: ____

Daily Activities at Home: ____

Hobbies: ____

Briefly give a history of your injury – Why are you here?

____

____

____

Past medical history: (Please list medications, ailments, past injuries, conditions, accidents, traumas).

____

____

____

List previous surgeries and dates: ____

____

____

Do you have any of the following medical conditions? Circle all that apply:

_____Rheumatoid Arthritis _____Osteoarthritis _____Autoimmune Disorders _____High Blood Pressure

_____Low Blood Pressure _____Dizziness _____Shortness of breath _____Cancer __________

_____Visual Disturbances _____Asthma _____Pregnancy _____Headaches

_____Pacemaker _____Implants ________________________ _____Siezures

_____Diabetes _____Depression _____Thyroid High/Low _____Weight Loss/Gain > 20 lbs

_____History of Falls _____Cardiac or Vascular issues____

OTHERS: ____

Have you had any of the following for this condition: ______X-Ray, ______MRI, ______EMG, ______

Other: ____________________.

CONNOLLY PHYSICAL THERAPY

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If so, are you aware of the results of these tests? Explain: ____

____

Have you had treatment for this condition before? Yes______ No _______

If yes, **when** and **what** did you receive treatment and what was treatment? ____________________________________

____

Do you have any known allergies? _______ Yes ________ No

If yes, please describe: ____

Do you exercise regularly? ________Yes ________No

If yes, what do you do and how often?

____

What are your goals for Physical Therapy? ____

____

Please indicate the amount of pain you are experiencing with your current condition:

0 1 2 3 4 5 6 7 8 9 10

Please shade in areas of pain on the diagram below:

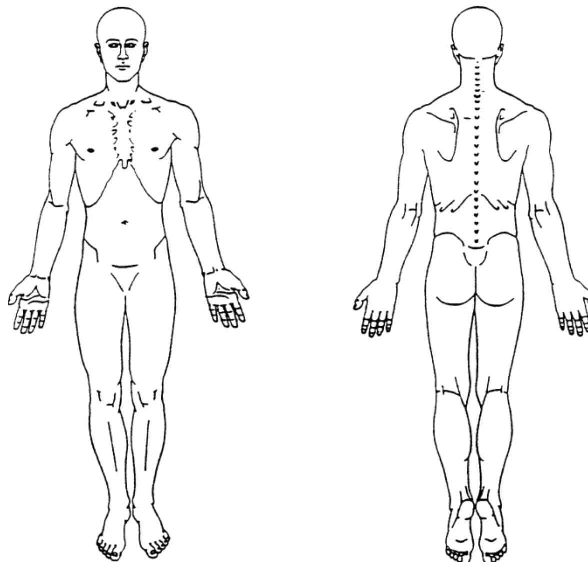
Key:

Numbness: ======

Pins/Needles: oooo

Burning Pain: xxxxxx

Stabbing Pain: //////



Patient Signature: ____Date: _____/_______/20_________

Therapist Signature: ____ Date: _____/_______/20_________