Drayer PHYSICAL THERAPY INSTITUTE

INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET

Patient Name: _____ **Date of Birth:** _____ **Date of Eval:** _____

SUBJECTIVE

Age: _____ **When did your symptoms start?** _____

Hand Dominance: ☐ **Right** ☐ **Left** **Date of next Doctor's appointment:** _____

Describe the current problem that brought you here: _____

_____

Are your symptoms: ☐ **Improving** ☐ **Getting Worse** ☐ **Staying the Same**

Have you had any testing? ☐ **X-rays** ☐ **MRI** ☐ **EMG/ Nerve Conduction Test** ☐ **CT Scan**

☐ **Other** **Results:** _____

Have you ever had these symptoms before? ☐ **Yes** ☐ **No** **Description:** _____

Have you ever had treatment before for these symptoms? ☐ **Yes** ☐ **No** **If Yes, please describe:**

☐ **Medication:** **Beneficial?** ☐ **Yes** ☐ **No** **Explain:** _____

☐ **Injection:** **Beneficial?** ☐ **Yes** ☐ **No** **Explain:** _____

☐ **Physical Therapy:** **Beneficial?** ☐ **Yes** ☐ **No** **Explain:** _____

☐ **Massage/Chiropractic:** **Beneficial?** ☐ **Yes** ☐ **No** **Explain:** _____

Did you have surgery? ☐ **Yes** ☐ **No** **Date of Surgery:** _____

If yes, what procedure did you have done? _____

Have you ever purchased or rented Durable Medical Equipment, Orthotics, Prosthetics, or Supplies?

☐ **Yes** ☐ **No** **Explain:** _____

THERAPIST COMMENTS:

FUNCTIONAL ABILITIES AND RESTRICTIONS

What were you doing prior to this injury that you are unable to do currently? Please list any additional activities that you are having difficulty completing. _____

☐ Squatting ☐ Sitting ☐ Driving ☐ Holding/Carrying Objects ☐ Work Tasks ☐ Gripping/Pinching ☐ Reaching
☐ Standing ☐ Walking ☐ Lifting ☐ Dressing/Grooming ☐ Stairs ☐ Position Changes ☐ Kneeling
☐ Other: _____

What household duties are you having difficulty performing? ☐ Cooking ☐ Cleaning ☐ Vacuuming ☐ Laundry
☐ Yard Work ☐ Grocery Shopping ☐ Other: _____

Do you use an assistive device? ☐ None ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: _____

Did you use an assistive device prior to current injury/conditions? _____

Hobbies/ Interests/ Exercise: _____

THERAPIST COMMENTS:

WORK HISTORY/ SOCIAL HISTORY/ INTERESTS/ LIVING ENVIRONMENT

Occupation: _____ **Presently Working:** ☐ **Yes** ☐ **No**

If Yes, ☐ **Full Duty** ☐ **Limited Duty: Restrictions:** _____ **# Days Off Work:** _____

Job Duties: ☐ **Sitting** ☐ **Computer Work** ☐ **Bending** ☐ **Heavy Lifting** ☐ **Traveling** ☐ **Standing**
☐ **Reaching** ☐ **Crawling** ☐ **Twisting** ☐ **Walking** ☐ **Pushing/Pulling** ☐ **Gripping/Pinching**
☐ **Other:** _____

Are you now, or have you ever been disabled (service or work)? ☐ **Yes** ☐ **No** **If Yes, when?** _____
If Yes, please explain: _____

What is your current living arrangement? ☐ **Alone** ☐ **Spouse** ☐ **Partner** ☐ **Family** ☐ **Other:** _____

Does your home have stairs? ☐ **Yes** ☐ **No** **If Yes, # of stairs:** _____

If Yes, do your stairs have handrail? ☐ **Yes** ☐ **No** **If Yes, which side going up?** ☐ **Right** ☐ **Left** ☐ **Both**

Do you currently use any Tobacco products? ☐ **Yes** ☐ **No** **If yes, what type?** _____ **Frequency:** _____

THERAPIST COMMENTS:

MEDICATIONS

Please list all of the medications [*with specific NAME, DOSAGE, FREQUENCY, and ROUTE (i.e., by mouth)*]
that you are currently taking [including over-the-counter, prescriptions, herbals, and vitamins/mineral(s)]:

_____

_____

THERAPIST COMMENTS:
☐ **See Attached List**

PATIENT GOALS FOR THERAPY

What are your goals for participating in Therapy? (i.e., performing household tasks without pain)

_____

_____

THERAPIST COMMENTS:

SIGNATURES

To the best of my knowledge I have fully informed you of the history of my problem and current status.

Patient's Signature: _____ **Date:** _____