THERAPY PARTNERS

PHYSICAL THERAPY ORTHOPAEDIC SPECIALISTS, INC. (PTOSI)

MEDICAL HISTORY/SUBJECTIVE INFORMATION

Date:________ Patient Name:______________________________

D.O.B._________ Patient Account #:______________________

Insurance: ____

Referral Source:________________________________

Primary Physician:______________________________

When did you first notice your symptoms or experience limitations?

First Episode ___/___/___ Most Recent Episode ___/___/___ Is this a recent flare-up? □Yes □ No

How did your symptoms arise? □ Auto □ Work □ Other Explain:____

What is your primary complaint? ____

Are your symptoms: □ Constant □ Intermittent
□ Increasing □ Decreasing □ Staying the same

What makes your symptoms worse?____

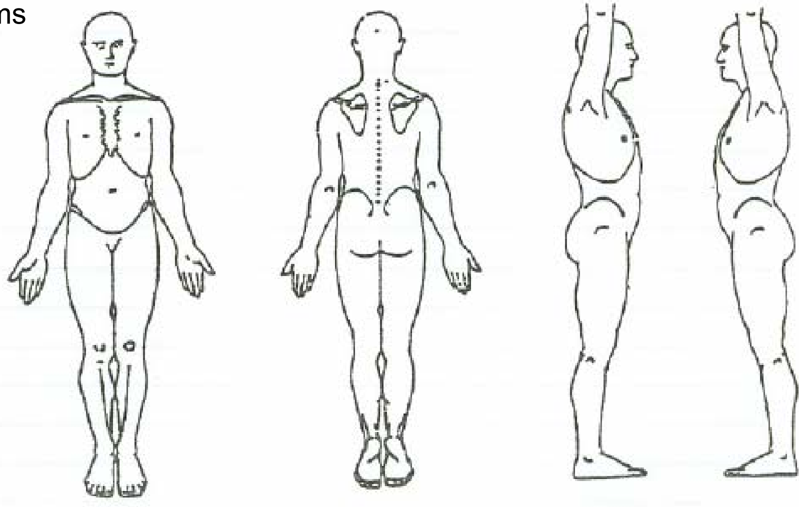
What makes your symptoms better? ____

Place an **"X"** on the line below indicating your pain at its lowest and highest levels.

(No pain) I___I___I___I___I___I___I___I___I___I___I (Worst pain imaginable)

Using the key below indicate on the body diagrams where your symptoms are located.

X=Pain
O=Tingling
//= Numbness



FOR THIS CONDITION HAS YOUR MEDICAL CARE INCLUDED: (Complete all that apply)

Surgery: When ___/___/___ What kind?______________________________ Did it help? □ Yes □ No

Injection: When___/___/___ What kind?______________________________ Did it help? □ Yes □ No

Physical Therapy From ___/___/___ To ___/___/___ What was done?___________________________________

Chiropractic From ___/___/___ To ___/___/___ What was done? ___________________________________

□ X-Ray____________ □ MRI ___________ □ CT ___________ □ EMG ____________ □ Other _____________________

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CURRENT LIMITATIONS (Check all that apply)

☐ Sleep ___hrs ☐ Sitting ___minutes ☐Standing ___minutes ☐ Self Care (bathe, dress)
☐ Home Management (chores, yard, shopping) ☐Reach ☐Lift ☐Recreation________________
☐Other____

WHAT ARE YOUR GOALS FOR THERAPY

☐Decrease Pain ☐Improve Sleep ☐Increase Sitting/Stand/Walk ☐Reach ☐Lift
☐Other____

GENERAL HEALTH

Age _____ Height _____ Weight _______lbs Dominate hand ☐ R ☐ L Do you smoke ☐ Y ☐ N
Are you pregnant ☐ Y ☐ N If yes ☐1st ☐ 2nd ☐3rd Trimester Do you regularly consume caffeine ☐ Y ☐ N
Do you exercise on a regular basis? if Yes, please list____

Have you ever been diagnosed with any of the following conditions?

☐ Y ☐ N High blood pressure	☐Y ☐ N Heart problems	☐ Y ☐ N Asthma	☐ Y ☐ N Tuberculosis
☐ Y ☐ N Depression	☐ Y ☐ N Kidney disease	☐ Y ☐ N Anemia	☐ Y ☐ N Thyroid problems
☐ Y ☐ N Diabetes	☐ Y ☐ N Multiple Sclerosis	☐ Y ☐ N Emphysema	☐ Y ☐ N Rh/Arthritis
☐ Y ☐ N Stroke	☐ Y ☐ N Hepatitis	☐ Y ☐ N HIV	☐ Y ☐ N Other Arthritis
☐ Y ☐ N Epilepsy	☐ Y ☐ N Chemical Depend.	☐ Y ☐ N Incontinence	☐ Y ☐ N Headaches
☐ Y ☐ N Dizziness	☐ Y ☐ N Osteoporosis	☐ Y ☐ N Cancer____________________________	

☐ Other____

Please list all of your medications ____

WORK INFORMATION

Who is your employer ________________________________ What is your Title ____________________________

Are you currently working ☐ Y ☐ N If yes, hours per week _____ ☐ Full duty ☐ Restricted duty

How many days of work have you missed due this condition _____ Do you have a QRC ☐ Y ☐ N

Have you consulted an attorney regarding your condition ☐ Y ☐ N

Patient Signature:____ Date ____/____/____

Your Therapist will complete the following section

SYSTEMS REVIEW ☐ Patient is NOT limited by factors in this section

Limitations related to: ☐ Communication ☐ Affect ☐ Cognition_________________ ☐ Modified ☐ Restricted
Other medical problems________________________________ Addressed by _______________________________
Transportation ☐ Self drive ☐ Driven by family member ☐Medical Transport ☐ Flexible ☐ Limited Access
Critical work/ADL/Leisure activities affected ____
Lift/Carry ☐ Low demand < 20# ☐ Mod/High >20# occasionally or 1# constantly or 10# frequently
Repetitive motion ☐ Low demand <33% of day ☐ Mod/High 34-100%
Static postures ☐ Sit ☐ Stand ☐ Crouch/Kneel ☐ Forward head ☐ Overhead
Leisure Activities ☐ Low demand (none or minimal impact) ☐ Mod/High (competitive, frequent, intense)

OVERALL FUNCTIONAL DEMAND LEVEL ☐ **LOW** ☐ **MOD/HIGH**

Other Information ____

Reviewed by Therapist: _______________________________________ Date ____/____/____
MD follow-up: ____/____/____ ☐ SEE SUPPLEMENTAL INFORMATION