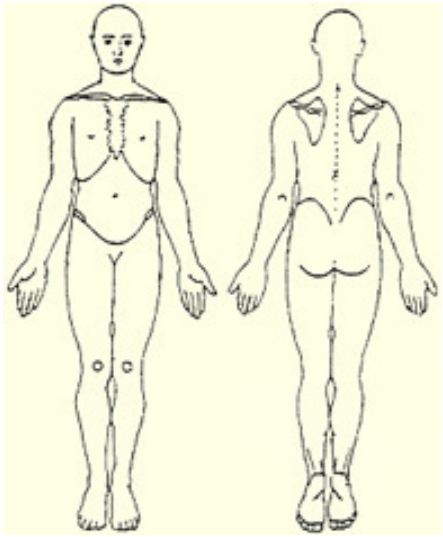
Uschi Schneider Physical Therapy

Physical Therapy Subjective Information Date:_____

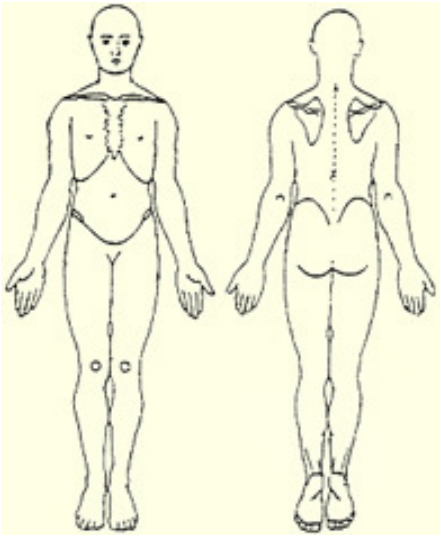
Name:_____ Age:_____ How old do you feel?_____
Occupation: _____ Do you enjoy what you do?_____
Marital /Relationship Status_____ Do you have children?_____
Primary complaint:_____
_____
Medical Diagnosis:_____Physician:_____

Area

Please mark the area of your symptoms on the body chart on the left



Please mark any scar tissue from surgeries or accidents on this body chart



Please describe your symptoms:_____
_____
Are your symptoms constant(☐) or intermittent(☐)
Do you have any numbness or tingling?_____ Do you get headaches?_____

Behavior

What activities or positions make your symptoms worse?_____
_____
What activities or positions alleviate your symptoms?_____
_____
What is your current activity level? Please list any sports or hobbies: _____
_____
What activities are you unable to participate in due to your symptoms?_____
_____
Are you symptoms worse in the morning or in the evening?_____
Did you receive prior treatment for your symptoms? Please describe_____
_____

Physical Therapy Subjective Information, page 2

Do your symptoms affect your sleep?_____

Do you have morning stiffness?_____

History

When was the exact date of the onset of your symptoms?_____

How did they start and how have they progressed since then?_____

_____

_____

Was this injury due to an accident?_____ A car accident?_____ Did it occur at work?_____

Have you had any diagnostic tests? (MRI, X-Ray, CT-scan)? If yes, please list dates and results. Please bring a copy of the imaging report to your first appointment. _____

_____

_____

Prior to onset of your symptoms, where you pain free?_____

Did you have a similar complaint before?_____

_____

Please list any motor vehicle accidents, falls or surgeries_____

_____

_____

_____

General Health

What other medical conditions do you have?_____

_____

_____

Have you ever had any serious illness?_____

Please list any medications or supplements you are taking:_____

_____

_____

Do you have any allergies or food sensitivities?_____

Are you pregnant?_____

Is there anything else I should know:_____

_____

_____

_____

What would the ideal outcome of today's visit be? What would you like to achieve through your therapy here?_____

_____

_____