SUBJECTIVE INFORMATION

Name:____

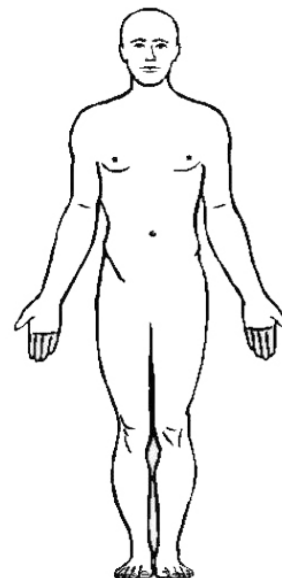
Age:______________ Height:______________ Weight:____________

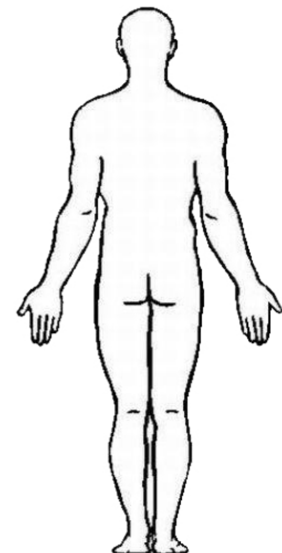
Occupation: ____

Please rate your pain:	0	1	2	3	4	5	6	7	8	9	10
At its worst	○	○	○	○	○	○	○	○	○	○	○
Currently	○	○	○	○	○	○	○	○	○	○	○
At its best	○	○	○	○	○	○	○	○	○	○	○

Pain location:

Using the diagrams below, please mark/draw your area of pain.





How do you alleviate your symptoms:

List movements that aggravate your pain:

When did your most recent injury start bothering you:

Is your injury: ☐Work related ☐Motor vehicle accident ☐Recreational ☐Other______________

What is the SPECIFIC cause of injury or series of events leading to your visit today?:

Describe how your symptoms change during the day (i.e. better, same, worse, stiff, etc)

Morning:_________________ Mid-Day:__________________ Evening:_________________

Do you wake up during the night because of pain? ☐Yes ☐No If yes, how many times?_____

Do you exercise and if so, what do you do?

	Yes	No
Do you have any metal plates or screws?	☐	☐
Are you pregnant?	☐	☐
Do you experience the following:	☐	☐
Headaches	☐	☐
Light-headedness	☐	☐
Nausea	☐	☐
Blurred vision	☐	☐
Numbness or tingling anywhere	☐	☐
Muscle cramping	☐	☐
Have you taken any steroids or anti-coagulants?	☐	☐

Do you have a history of the following:	Yes	No
Cancer	☐	☐
Cardiac Problems	☐	☐
Hypertension	☐	☐
Pacemaker	☐	☐
Diabetes	☐	☐
Osteoporosis	☐	☐
Rhematoid Arthritis	☐	☐
Depression	☐	☐

Have you fallen at all this past year? ☐Yes ☐No

If yes, when was the most recent episode?

List all medications you are currently taking with dosage and frequency:

Have you had an X-Ray or MRI taken? ☐Yes ☐No

What were the results?

Any prior surgeries?

Are you currently recieving home therapy (PT, OT, Speech, Nursing)? ☐Yes ☐No

THE ABOVE ANSWERS ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature:____ Date__________________