Outpatient Medical History / Subjective Information **Date: / /**

Name: ______________________ Birthdate: __________ Age: ________ Sex: M F

Preferred Learning Style:(circle) Reading Hearing Seeing Doing Other:__________ Primary Language:______________

Medical History (Please check all that apply)

☐ Heart Disease	☐ Diabetes	☐ High Blood Pressure	☐ Pacemaker
☐ Cancer	☐ Epilepsy	☐ HIV/AIDS	☐ Arthritis
☐ Hearing/ Visual Impaired	☐ Stroke	☐ Asthma	☐ Latex Allergy
☐ Osteoporosis	☐ Hepatitis	☐ Kidney/ Bladder Control	☐ Dizziness

If you are female, is there any possibility that you are pregnant? Yes No N/A

TB Screening

Recent history of persistent cough?	Yes	No	Recent history of persistent fever?	Yes	No
Recent history of night sweats?	Yes	No	Recent history of unexplained weight loss?	Yes	No
History of treatment or exposure to TB?	Yes	No			

Please list all medications currently taking ______________________________

Please list all operations you have had related to current issue: ______________________________

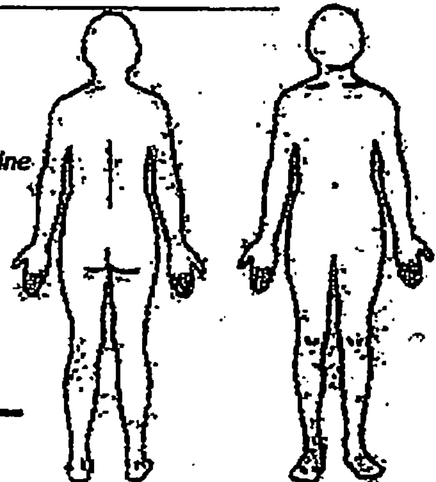
Please list any allergies to drugs, food, or environment: ______________________________

Injury/Problem Information

How and when did the injury or problem occur? ______________________________

Have you had any prior/previous treatment for this injury? X-RAY MRI CAT SCAN Physical Therapy Injections Chiropractic Services Massage Therapy Acupuncture Other:______________

Please indicate on the image where the pain or problem is located:



Is your pain: Constant Intermittent (Please circle one)

Please rate your pain using a 0 – 10 scale: (Please circle one)

0 = no pain at all, 5 = pain interferes with daily tasks 10 = worst pain you can imagine

Todays Pain? *0 1 2 3 4 5 6 7 8 9 10*

Worst pain since onset? *0 1 2 3 4 5 6 7 8 9 10*

Best pain since onset? *0 1 2 3 4 5 6 7 8 9 10*

What makes your pain/problem better? ______________________

What makes your pain/problem worse? ______________________

Physical Therapy Goals and Expectations:

What problems are you experiencing because of your diagnosis or injury?

1)______________________ 2)______________________

What are your goals for Physical Therapy?

1)______________________ 2)______________________

Employment History: (Work injury patients only)

Are you currently working? Yes No If no, how many days have you missed? ______________________

Are your work duties: Full Time Light Duty Special Restrictions How many hours a week do you work? ________

Who is your employer? ______________________

What kind of work do you do? ______________________

What work duties have been most affected by your problem? ______________________

____

____

CONSENT TO TREAT:

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services at OakBend Medical Center. I have received a copy of The Patient/Client Rights and Responsibilities Information Sheet.

Patient Signature: ______________________

Date: ______________________

Therapists Section:

Identified needs for community resources: Child/Youth Senior Adult Support Groups

Plans to address special learning factors/barriers (as identified): ______________________

Therapist Signature: ______________________ **Date:** ______________