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

Please list all medications currently taking _____

_____

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

_____

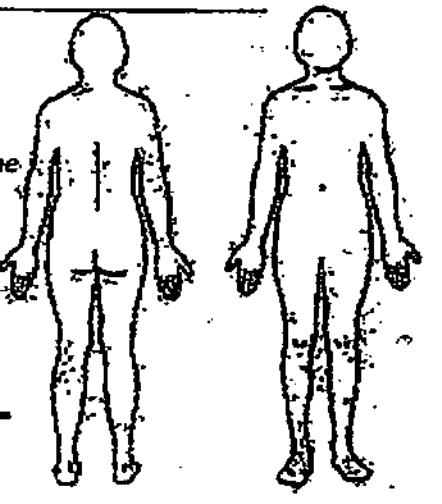
Please list any allergies to drugs, food, or environment: _____

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: _____