Date:________ Patient Name:_____________________________

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

Insurance: ________________________________________

**THERAPY PARTNERS**

MINNESOTA SPORT & SPINE REHABILITATION (MSSR)

**SUBJECTIVE/MEDICAL HISTORY INFORMATION**

## HISTORY OF CURRENT CONDITION

**What body part are we seeing you for today?**

□ **Right** □ **Left** ___________________________________

1. Which of the following **best describes** how your injury occurred? (if your injury is post-surgical please indicate as per original injury

□ lifting □ dental appointment
□ a fall □ degenerative process
□ an incident at work □ unknown
□ overuse (cumulative trauma) □ other____________
□ during recreation/sports_________________
□ MVA (car accident) State accident occurred __________

*Please indicate the date your symptoms began?
(Please indicate specific date if possible) ____/____/_____
Surgery date (if applicable) ____/____/_____

2. Nature of primary complaint: □ Pain □ numbness/tingling

□ sharp □ aching □ constant
□ dull □ burning □ weakness
□ throbbing □ intermittent □ other_______________

Using the key below indicate on the body diagrams where your symptoms are located. **X**=Pain **O**=Tingling **//**= Numbness

R L L R R L

R L L R R L

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

0 ☺ I___I___I___I___I___I___I___I___I___I___I 10 ☹

3. Was the **onset** of this episode gradual or sudden? (check one)

□ gradual □ sudden □ flare up

If this is a flare up: original date of onset_______
Number of prior episodes______ Frequency_________

4. Since onset are your symptoms getting: (check one)

□ better □ worse □ not changing

5. What relieves (R) / aggravates (A) your symptoms

___ sitting ___ rest ___ massage
___ heat ___ standing ___ medication
___ cold ___ walking ___ nothing
___ stretching ___ exercise ___ lying down
___ wearing a splint/brace ___ coughing/sneezing
___ other __________________________________

6. As the day progresses do your symptoms: (check one)

□ increase □ decrease □ stay the same

7. Does pain wake you at night? □ Yes □ No

If "yes", is it present

□ while lying still □ when changing positions □ both

8. In what position do you sleep? (check all that apply)

□ right side □ back □ back, sides, stomach
□ left side □ chair/recliner □ stomach
□ other ___________________________________

9. Do you have pain/stiffness getting out of bed in the morning? □ Yes □ No

10. Since your symptoms began have you had: □ None

□ fever / chills / nausea / vomiting
□ any numbness in genital/anal area
□ numbness / tingling / burning
□ dizziness / fainting
□ weakness
□ unexplained weight change
□ night sweats / pain
□ problems with vision / hearing / speech
□ any difficulty with bladder/bowel function
□ Headaches □ other____________________________

11. Current limitations (check all that apply) □ None

□ sitting ____________ □ standing ___________
□ going from sit to stand □ walking ____________
□ lying down □ up/down stairs
□ reaching ____________ □ squatting
□ bending □ looking overhead
□ taking a deep breath □ swallowing
□ talking / chewing / yawning / all (circle one)
□ self care/hygiene ___________________________
□ home management activities_________________
□ repetitive activities _________________________
□ sports / recreation __________________________

12. Treatments previously received for this condition?
(check all that apply) □ None

□ medication □ biofeedback/TENS
□ Chiropractic □ TENS unit
□ Physical therapy □ injection/acupuncture
□ massage □ casting/immobilization
□ bracing/taping □ hospitalization
□ surgery (date) ____________________________________
□ other_____________________________________________

13. Please check /list any other health care providers you are currently seeing for this condition: □ None

□ MD __________________ □ Dentist
□ Podiatrist □ Chiropractor
□ Physical therapist

14.Please check if you have you had any of the following?

□ none □ EMG □ x-rays
□ CT scan / MRI □ other _________________________

Date:________ Patient Name:_____________________________ Patient Account #:_____________________

## GENERAL HEALTH

Age: ____ Height:______ Weight:______

Dominant hand (circle): **R L**

How would you rate your overall health?
□ Excellent □ Good □ Average □ Fair □ Poor

Are you pregnant □ No □ Yes date due:___/___/___

Apart from your daily activities do you exercise? □ zero
□ 5+ days/wk □ 3-4 days/wk □ 1-2 days/wk □ occasionally

Do you drink caffeinated beverages? □ No □ Yes _____/day

Do you smoke? □ No □ Yes _____packs/day

What is your stress level? □ Low □ Medium □ High

Are there any other issues or concerns in your life that you would like us to know about and/or that may affect your ability to benefit from physical therapy treatment? □ No □ Yes

If yes, please explain: ________________________________
____________________________________________________
____________________________________________________
____________________________________________________

## MEDICATION

Please list any prescription and/or over the counter medications you are currently taking (pain pills, injections, skin patches, aspirin, multi vitamins, etc) □ **see attached list**

______________________ ______________________
______________________ ______________________
______________________ ______________________

## PAST/CURRENT MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions? (check all that apply) □ None

□ Cancer _______________
□ Heart problems
□ HIV
□ Stroke
□ Kidney problems
□ Thyroid
□ Epilepsy/seizures/dizziness
□ Diabetes
□ Arthritis-OA/RA,osteopenia/osteoporosis
□ Head injury
□ Circular/vascular problems
□ Chemical dependency
□ High blood pressure
□ Depression
□ Lung problems/asthma
□ Incontinence
□ Blood disorder/anemia
□ Multiple Sclerosis
□ Allergies
□ Fractures
□ Stomach problems
□ Parkinson's
□ Infectious disease (i.e. hepatitis, tuberculosis, etc.)
□ Spine problems / surgery □ Other_________________
□ List any other surgeries______________________________

## FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been diagnosed with any of the following?

□ Diabetes □ Stroke □ Cancer _______________
□ Heart disease □ Arthritis OA/RA
□ High blood pressure □ Psychological condition
□ other_______________________________________

## LIVING SITUATION

□ live alone □ live with family members/others/caregiver
□ home / apartment / retirement complex (independent/assisted)
□ driving □ other__________________________

**Environment**

□ stairs (railing) □ no stairs
□ stairs (no railing) □ elevator
□ other__________________________________________

## PREVIOUS FUNCTIONAL LEVEL

□ **Independent in all activities** (work, home, recreation, community)

**Self Care**

□ Independent (bathing, toileting, dressing, etc.)
□ Difficulty performing self care activities
□ Need assistance with self care activities
□ Difficulty performing household chores

**Social/Recreational/Leisure**

□ Limited in________________________________________

**What are your goals for therapy?** ____________________
______________________________________________________

**Have you had any falls or near falls in the past year?**
□ Yes □ No

## WORK HISTORY

**Occupation**__________________________________

□ full time □ self □ student
□ part time □ retired □ unemployed
□ other______________________________

**Physical activities at work**

□ sitting □ standing □ computer use
□ phone use □ repetitive lifting □ driving
□ heavy equipment operation □ heavy lifting

**Current working status** □ full duty □ restricted duty

Work days missed_______

If not performing your normal activities at work do you plan to return to your previous activity level? □ Yes □ No

If this is a Work Comp claim - Do you have a QRC (Qualified Rehabilitation Consultant) □ Yes □ No

Are you seeking disability or are you consulting an attorney for this condition? □ Yes □ No

**M.D. follow up appointment** _____/_____/_____

**Patient / guardian signature:** _______________________

**Reviewed by therapist:** ____________________________

**Date:** _____/_____/_____

**Reviewed/Updated** ____________________ **Date** ______

**Reviewed/Updated** ____________________ **Date** ______