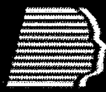


The Center For Physical Health

Physical Therapy Subjective Information

Name:______________________________ Age:_______ Date_____________

Occupation:________________________ Medical Diagnosis: ______________________________

Whom may we thank for recommending you to The Center for Physical Health? _______________________

Present History:

1) When was the exact date of the onset of your symptoms? ____

2) How did your symptoms first start? ____

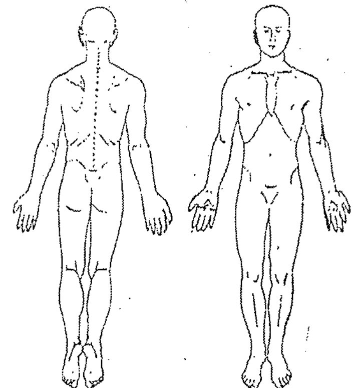
3) Since first onset of your symptoms, are they improving, worsening, or staying the same (please circle)

4) Prior to the onset of your symptoms, were you pain free? ____

5) Have you had any prior treatment for your symptoms (if yes, please explain) _________________________

____

Area of Symptoms:



1) Please mark the area of your symptoms on the body chart to the right.

2) How would you describe your symptoms? (stiff, achy, dull, sharp, etc) ________

____

3) Do you have any numbness or tingling? If so, where? ______________________

4) Are your symptoms constant [___] or intermittent [____]? If intermittent, how often do you get your symptoms? ____

5) Do you get headaches? Yes [___] No [___]

Symptom Behavior:

1) What activities or positions make your symptoms worse? ____

2) What activities or positions make your symptoms better? ____

3) What is your current activity level, including ability to complete daily tasks, exercise, and/or sports

____

4) What activities are you unable to participate in as a result of your symptoms? _________________________

5) Are your symptoms worse in the morning, or in the evening? ______________________________________

6) Do your symptoms ever wake you up at night? Yes [___] No [___]

7) Do you have morning stiffness? If so, how long does it last? _______________________________________