

CASCADE REHABILITATION ASSOCIATES

MEDICAL HISTORY/SUBJECTIVE INFORMATION

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Your Name: _____				Today's Date: _____
Date of Birth: _____	Age: _____	Height: _____	Weight: _____	Do You Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female If female, are you currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, <input type="checkbox"/> 1 st Trimester <input type="checkbox"/> 2 nd Trimester <input type="checkbox"/> 3 rd Trimester				

Have you ever been diagnosed with any of the following?

- | | | | | | |
|-----------------|--|-----------|--|----------------------|--|
| Tuberculosis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Cancer | <input type="checkbox"/> No <input type="checkbox"/> Yes | Arthritis | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Stroke | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Condition | <input type="checkbox"/> No <input type="checkbox"/> Yes | Epilepsy | <input type="checkbox"/> No <input type="checkbox"/> Yes | Respiratory Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Other: _____

Who referred you to physical therapy? _____

Primary Physician _____

Tell Us About Your Condition

When did you first notice the pain or have functional problems due to the condition/injury? (Please provide approximate dates): _____

Recent flare-up? No Yes If yes, when _____

What activities are limited by this condition? (e.g. lift, reach): _____

How did your injury/symptoms occur? _____

What do you expect to accomplish with physical therapy? _____

Are your symptoms: Constant? Intermittent? Getting Better?
 Getting worse? Staying the same?

What makes your symptoms better? _____

0-10 pain scale (0 = No Pain; 5= Moderate Pain; 10 = The Most Extreme Pain)

Worst pain rating: 0 1 2 3 4 5 6 7 8 9 10

Best pain rating: 0 1 2 3 4 5 6 7 8 9 10

For this injury, has your medical care included: (check those that apply)

Surgery: When? ___/___/___ What kind? _____

Injection: When? ___/___/___ Did it help? Yes No

Other treatment:

Physical therapy If yes, when? ___/___/___ to ___/___/___
 What was done? _____

Chiropractor If yes, when? ___/___/___ to ___/___/___
 What was done? _____

Medications: _____

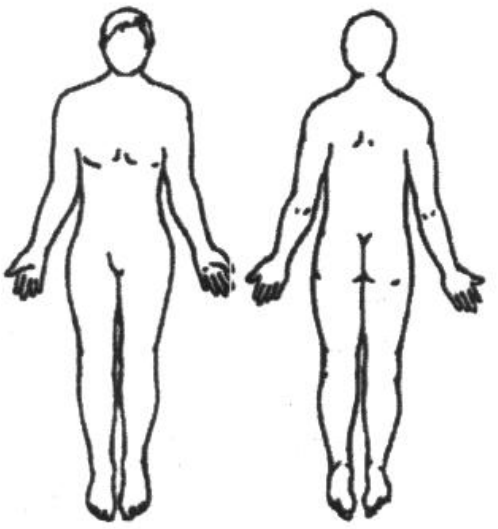
X-ray _____ MRI _____

CT scan _____ Other: _____

Exercises: What kind? _____

Indicate on body diagrams **where** your symptoms are located

■ = Pain III = Numbness



Comments: _____

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Work Information

Who is your employer? _____

What is your job title/responsibilities? _____

Are you currently working? No Yes If yes, numbers of hours per week _____
 Full Duty Restricted Duty

How many total work days have you missed? _____ Do you have a case manager/QRC? No Yes

Your Therapist Will Complete This Section

Critical work, ADL, or leisure activities affected: _____

- Lift/carry: ≤ 20 lbs. rarely to occasionally (**low demand**)
 > 20 lbs., or > 11lb. constantly or > 10 lb. frequently (**mod-high demand**)
 Where to where _____ to _____.
- Repetitive motions related to condition: Occasional 1-33% (**low demand**)
 Frequent to Constant 34-100% (**mod-high demand**)
- Static positions related to condition (**mod-high**): Sit Stand Crouch
 Kneel Overhead work _____
- Leisure Activities: None/minimally impact condition (**low demand**)
 Moderate-high intensity, competitive (**mod-high demand**)

Overall functional demand (work/ADL/leisure) Low Demand Moderate-High Demand

Comments: _____

Additional Comments: _____

Indicate either "Yes" or "No" as to whether each of the following activities is difficult.

Drinking or Eating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Balancing on both feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleeping Through the Night	<input type="checkbox"/> Yes <input type="checkbox"/> No	Walking on: stairs, flat surfaces, inclines, uneven surfaces, ladders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dressing: Putting on or taking off shoes, socks, shirt, jacket or pants	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lifting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Maintaining static position of; Head bent forward, arms overhead, arms forward, or turning head	<input type="checkbox"/> Yes <input type="checkbox"/> No	Carrying	<input type="checkbox"/> Yes <input type="checkbox"/> No
Getting in/out of: chairs, bed, car or bath/shower	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bending, Kneeling Squatting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reaching: overhead, behind back, downward for forward	<input type="checkbox"/> Yes <input type="checkbox"/> No	Driving a vehicle or ability to use gas/brake pedals	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gripping, Holding tools or Opening Jars	<input type="checkbox"/> Yes <input type="checkbox"/> No	Caring for child or adult	<input type="checkbox"/> Yes <input type="checkbox"/> No
Picking up Small Objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Housework / Yard work	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sitting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recreational Activities	<input type="checkbox"/> Yes <input type="checkbox"/> No
Standing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you fallen more than 1 time in the past year	<input type="checkbox"/> Yes <input type="checkbox"/> No
Job Related Activities	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you fallen and hurt yourself in the past year	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other: _____