GARDENA PHYSICAL THERAPY

Subjective Information

Date:_____ Name:_____ Age:_____

Date of Injury:_____ Occupation:_____

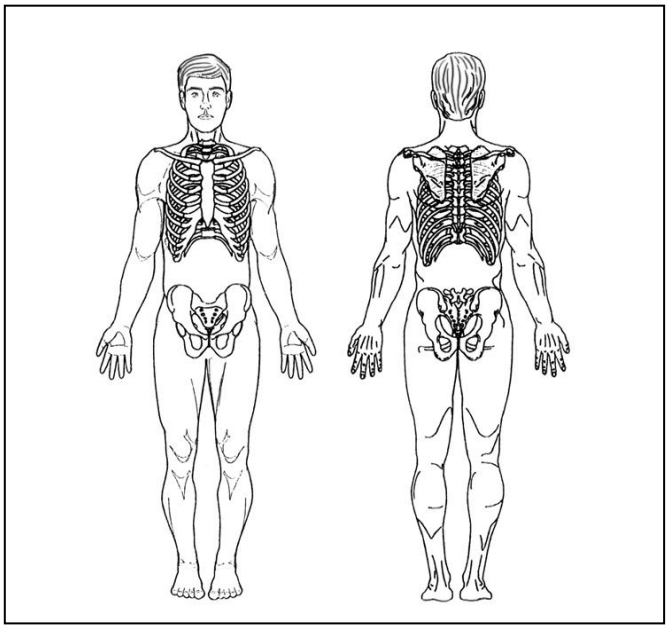
Are you currently working? Yes No Referring Doctor:_____

Height:_____ Weight:_____ Dominant Hand: (please circle) Right or Left

---

Present Injury:

1. Lightly draw in all areas of pain, stiffness, ache, etc., on the drawing to the right.
2. Label the spot of your worst pain.
3. Circle any areas of numbness or tingling.



When did this happen?_____

Where did the injury occur?_____

Was this due to an injury at home? _____Yes _____No

Was this due to an auto accident? _____Yes _____No

Is this a post-surgical condition? _____Yes _____No

Is this a pregnancy related condition? _____Yes _____No

Was this due to a recreational injury? _____Yes _____No

Did this happen due to no particular cause? _____Yes _____No

Was this due to an injury at work? _____Yes _____No

Was this due to a motor vehicle accident while at work? _____Yes _____No

Behavior:

Patient Name: _____

What activities or positions ease your symptoms?

_____Doing exercises _____Sitting

_____Heat or a hot shower _____Walking

_____Ice _____Rest

_____Lying on your back with knees up

_____Lying on side in fetal position

What activities make your pain worse (mark the worst 2-4 items from list)?

_____Bend w/twist _____Housework _____Running

_____Bending _____Getting in/out of bed _____Sitting

_____Biting into an apple _____Getting in/out of car _____Sports

_____Computer Work _____Going from sit to stand _____Squatting

_____Coughing _____Lifting _____Turning head

_____Deep breathing _____Looking down _____Walking

_____Doing hair _____Looking up _____Walking down stairs

_____Dressing _____Lying down _____Walking up stairs

_____Driving _____Lying on stomach _____Yawning

_____Eating _____Reaching

Check one of the following:

Do symptoms _____increase _____decrease or _____stay the same by the end of the day?

When did you first see a Doctor?_____ Dr's Name:_____

Have you had any treatment for this so far? Yes No If yes, please explain:_____

_____

List any other Drs. seen for this problem and what treatment was provided:

1. _____
2. _____

Patient Name: _____

Have you had any of the following for this injury?:

Brace Cast CT Scan EMG Injection MRI Surgery Xray None of the above

What most describes your symptoms: _____Constant _____Intermittent (comes and goes)

If your symptoms are intermittent, how often do you get them? Check one:

_____Daily _____1-2 times/week _____3-5 times/week

How do you describe your symptoms? Check all that apply:

_____Stiffness _____Ache _____Heaviness _____Shooting Pain
_____Numbness/Tingling

On a scale of 0-10, with 10 being the worst pain imaginable and 0 being no pain, where are you on the following scale?

0----------2----------4----------6----------8----------10

Do you get headaches? _____Yes _____No

If yes, how many times per week? _____Times/week

Do you feel your symptoms are **decreasing**, **increasing**, or **staying the same**?

History:

What medications are you now taking?:_____
_____

Are you pregnant? _____Yes _____No _____Possibly

Do you have any metal implants? _____Yes _____No

Do you have or have you ever had, any of the following: (please circle all that apply)

Allergies Asthma Cancer Cardiac Problems Diabetes Osteoperosis

High Blood Pressure Pacemaker Respiratory Problems Seizures Dizziness

Describe **any** previous surgeries, injuries, or illness (***related*** or ***unrelated*** to your present injury)

Please include dates:

1. _____
2. _____

Patient Signature:_____ Date:_____

Patient Name: _____

GARDENA
PHYSICAL THERAPY

Functional Assessment

Please **circle 3 or more** of the following activities that cause you the most pain or are the most difficult for you to perform. Please be sure to note your pain level (0-10) with each activity you choose.

Activity		**Pain Level 0-10**
Sitting:	How long can you sit without pain? _____	Pain: _____
Standing:	How long can you stand without pain? _____	Pain: _____
Walking:	How long can you walk without pain? (time or distance) _____	Pain: _____
Stairs:	Can you use stairs without pain? How many steps? _____	Pain: _____
Squatting:	Can you squat to pick something up from the floor without pain? _____	Pain: _____
Dressing:	Do you have any pain when getting dressed / undressed? _____	Pain: _____
Reaching:	Do you have any pain with reaching overhead? _____	Pain: _____
Lifting:	Do you have any pain lifting objects? How heavy? _____	Pain: _____
Housework:	How long can you do housework without pain? _____	Pain: _____
	Which specific activities bother you? _____	
Work:	Can you perform your normal work duties without pain? _____	Pain: _____
	Which duties: _____	
Other:	Any other activities that bother you? _____	Pain: _____
	_____	

Please list any specific goals that you would like to achieve by attending physical therapy

1. _____
2. _____
3. _____

Patient Name: _____