KPT Corporation
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? ☐ Yes ☐ No**
Sex: ☐ Male ☐ Female If female, are you currently pregnant? ☐ **No** ☐ **Yes**				**Social Security #:**
Home Phone:	**Mobile Phone:**			**Work Phone:**
Street Address: **City:**	**State:**	**Zip Code:**		**Emergency Contact:**_____ **Emergency Contact #:**_____
Email:				**OK to email you occasionally with clinic updates? Yes____ No____**
Insurance:	**Name of Insured:**			**Relationship to Insured:**
Policy Number:	**Grp. Number:**			**Primary Physician:**

Work Information

Who is your employer?	**Work Phone:**
What type of work do you do?	**Are you currently working?**
How many hours per week do you work?	☐ **Full Duty** ☐ **Restricted Duty**
How many total work days have you missed? _____	**Do you have a case manager?** ☐ No ☐ **Yes**_____

Have you ever been diagnosed with any of the following?

Pacemaker	☐ No	☐ Yes	Cancer	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Osteoporosis	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Heart Condition	☐ No	☐ Yes	Seizures	☐ No	☐ Yes	Respiratory Problems	☐ No	☐ Yes

Previous Surgeries:_____
Medicines:_____
Who referred you to physical therapy? _____
Have you fallen in the last year?:_____

Tell Us About Your Condition

Where and how did your injury/symptoms occur? ☐ Recreation ☐ Home ☐ Work ☐ Auto Accident ☐ Unknown ☐ Other _____
_____
When did you first notice the pain or have functional problems due to the condition/injury? (Specific date) - ____/ ____/ ____
_____ Recent flare-up? ☐ No ☐ Yes If yes, when ____/ ____/ ____ _____
What activities are limited by this condition? (e.g. lift, reach) _____
What are your goals for 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; 10 = The Most Extreme Pain)
Worst pain rating: _____ **Best** pain rating: _____
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: _____

Indicate on body diagrams **where** your symptoms are located
■ = Pain ***III*** = Numbness **XX** = Weakness