

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? <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				Social Security #:	
Home Phone:		Mobile Phone:		Work Phone:	
Street Address:				Emergency Contact: _____	
City:		State:	Zip Code:	Emergency Contact #: _____	
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?	<input type="checkbox"/> Full Duty <input type="checkbox"/> Restricted Duty
How many total work days have you missed? _____	Do you have a case manager? <input type="checkbox"/> No <input type="checkbox"/> Yes _____

Have you ever been diagnosed with any of the following?

- | | | | | | |
|-----------------|--|--------------|--|----------------------|--|
| Pacemaker | <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 | Osteoporosis | <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 | Seizures | <input type="checkbox"/> No <input type="checkbox"/> Yes | Respiratory Problems | <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> Constant? <input type="checkbox"/> Intermittent? <input type="checkbox"/> Getting Better? <input type="checkbox"/> Getting worse? <input type="checkbox"/> 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) <input type="checkbox"/> Surgery: When? ___/___/___ What kind? _____ <input type="checkbox"/> Injection: When? ___/___/___ Did it help? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other treatment: <input type="checkbox"/> Physical therapy If yes, when? ___/___/___ to ___/___/___ What was done? _____ <input type="checkbox"/> Chiropractor If yes, when? ___/___/___ to ___/___/___ What was done? _____ <input type="checkbox"/> Medications: _____ <input type="checkbox"/> X-ray _____ <input type="checkbox"/> MRI _____ <input type="checkbox"/> CT scan _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/>
Exercises: What kind? _____

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

■ = Pain **III** = Numbness **XX** = Weakness

