Quality Therapy Services, Inc.
PHYSICAL THERAPY
OCCUPATIONAL THERAPY

Initial Subjective Patient Assessment

Patient Name: _____ Date of Birth: _____ Date you return to your Doctor _____

INFORMATION ABOUT CURRENT CONDITION

For what condition/illness/injury/surgery were you referred to PT? _____

When did condition begin? _____ **Have you recently been hospitalized**? ☐ yes ☐ No **Date** _____ to _____

Have you had surgery for this condition? ☐ yes ☐ no **Type of surgery**? _____ **Date of surgery?** _____

Have you had any special tests related to this condition? ☐ X-ray ☐ MRI ☐ CAT SCAN ☐ Bone scan
Other _____

Symptoms for this condition:

☐ Pain (see below)	☐ Numbness arms/legs	☐ Difficult mobility	☐ Increased falls
☐ Headaches	☐ Decreased function	☐ Decreased ability to walk	☐ New weakness
☐ Tingling arms/legs	☐ Difficulty dressing	☐ New need for device with walking	☐ Joint stiffness
☐ Limb swelling	☐ Difficulty bathing	☐ Difficulty negotiating steps	☐ muscle spasm

What are the patient's/ caregiver's goals for the outcome of PT intervention? _____

Medications _____
Allergies _____

PAIN

Location _____ **Rate pain** on a scale of 0-10. (0 =no pain, 10= max pain) _____
Occurrence ☐ seldom ☐ intermittent ☐ constant **Severity** ☐ mild ☐ moderate ☐ severe
Pain improves with : ☐ rest ☐ positioning ☐ ice ☐ heat ☐ activity ☐ massage ☐ exercise
Other _____
Pain worsens with: ☐ prolonged activity ☐ straining ☐ Bending ☐ change in position
Other _____
Description ☐ aching ☐ burning ☐ throbbing ☐ dull ☐ sharp ☐ shooting ☐ heaviness

FUNCTIONAL LEVEL PRIOR TO CONDITION

Describe your functional level PRIOR to the onset of your current condition

Walking/stairs:	☐ No problems	☐ No device used	☐ Cane	☐ Walker	☐ No fatigue	☐ Fatigue
Primary means of mobility:	☐ Walking	☐ Wheelchair	☐ Assistance needed			
Assist with daily tasks:	☐ None	☐ Assisted bathing	☐ Assisted dressing	☐ Assisted grooming		
Assist with mobility tasks	☐ None	☐ Minimal	☐ Maximum			
Lifestyle :	☐ Working	☐ School	☐ Sports	☐ Recreation		

Work status : Out of work due to condition? ☐ no ☐ yes ,date out of work? _____ light/modified duty? ☐ yes ☐ no
What is your occupation? _____ Physical requirements _____

How would you rate your current health? ☐ excellent ☐ good ☐ fair ☐ poor
Notes _____

Patient Signature or person completing form on patient's behalf: _____ Date _____

Relationship to patient, if other than patient _____

Reviewed by Therapist: _____ Date: _____

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Patient Name

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following?

Yes	Yes	Yes	Yes	Yes
☐ HIV	☐ Phlebitis	☐ Mononucleosis	☐ Seizure	☐ High Blood Pressure
☐ Parkinson's Disease	☐ Tuberculosis	☐ Respiratory Problems	☐ Low Blood Pressure	☐ Elevated Cholesterol
☐ Hepatitis	☐ GI Problems	☐ Diabetes	☐ Kidney Disease	☐ Rheumatoid Arthritis
☐ Joint replacements	☐ Depression	☐ Arthritis	☐ Broken Bones	☐ Orthopedic surgery
☐ Psychiatric condition	☐ Heart Disease	☐ Heart Attack	☐ Lymphedema	☐ Chemical Dependency
☐ Cancer	☐ Surgery	☐ Incontinent	☐ COPD	☐ Congestive heart failure

Are you pregnant? (females) ☐ yes ☐ no; ☐ right handed ☐ left handed; Metal in your body? ☐ yes ☐ no

If yes please give details _____

other _____

HEALTH SERVICES

Other health services currently receiving: ☐ Dentist ☐ PT/OT/ ST ☐ Medical Doctor ☐ Personal care ☐ Psychiatrist ☐ Osteopath ☐ Chiropractor ☐ Home Health

Have you been discharged from a hospital, nursing home or home health agency in the past 30 days? ☐ yes ☐ no

Other facilities I have received PT from for this condition in the past year:: approximate date range of service _____

☐ Hospital ☐ Rehab Center ☐ Nursing home ☐ Home health ☐ Other outpatient PT facility

Outcome of condition from prior PT services ☐ Improved ☐ same ☐ worse **Number of visits** _____

HOME ENVIRONMENT

Where do you live? ☐ House ☐ Apartment ☐ Assisted living facility

Who lives with you? ☐ No one/living alone ☐ With family member/friend ☐ With hired help other _____

Is this situation permanent or temporary? _____

What medical equipment do you have?

☐ Single point cane	☐ Walker with wheels	☐ Walker without wheels	☐ Bath bench
☐ Four prong cane	☐ Hemi walker	☐ Walker with seat and wheels	☐ Bedside commode
☐ Elevated toilet seat	☐ Manual wheelchair	☐ Power wheel chair	☐ brace

Other/Notes _____

Patient Signature or person completing form on patient's behalf: Date

Relationship to patient , if other than patient

Reviewed by Therapist: Date: