SPARROW
OUTPATIENT
REHABILITATION

Last Name, First Name	Physician
Date of Birth	

MEDICAL HISTORY AND SUBJECTIVE INFORMATION FORM

Please answer the following questions as completely as possible. **Please** use **black ink only**, and **do not fill in shaded areas.** Shaded areas are for **OFFICE USE ONLY**. If you need help filling out this form, we would be happy to assist you.

Name: ____ **Birth Date:** ________________**Today's Date:** ________________

*Date of injury/problem:	*Date you went to your doctor for help with this injury/problem:
***Briefly describe how your problem occurred. (Include dates if possible.)**	
Therapist Comments:	
***What would you like to accomplish in therapy (what are your goals)?**	

Rate your pain on a scale from 0-10 (0=no pain, 10=worst pain): *Current____ *Best____ *Worst____

Describe your pain: ☐Constant ☐Intermittent ☐Sharp/Stabbing ☐Dull /Aching ☐Burning ☐Throbbing ☐Other:

What makes your Pain/Symptoms…

*Better (or decreases your pain):____

____

*Worse (or increases your pain):____

____

When are your symptoms better: ☐AM ☐PM ☐Other:____________________

When are your symptoms worse: ☐AM ☐PM ☐Other:____________________

Does your pain wake you? ☐No ☐Yes: ____________________________

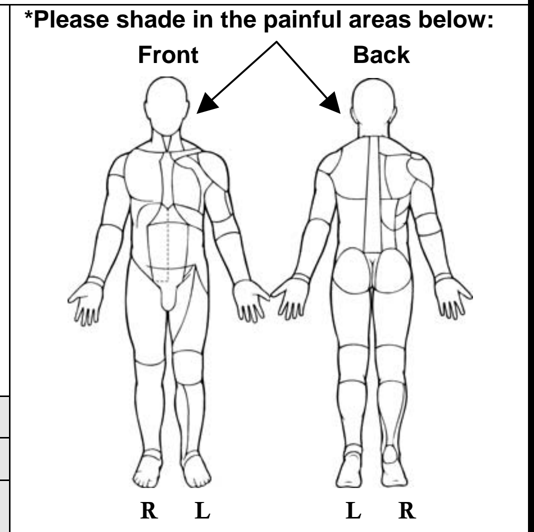
Do you sleep through the night? ☐No ☐Yes: ____________________________

*Do you have numbness? ☐No ☐Yes, location: ____________________________

*Do you have tingling? ☐No ☐Yes, location: ____________________________

Therapist Comments:

***Please shade in the painful areas below:**



***PREVIOUS TREATMENT(S)** for this condition (please check all that apply): ☐**None**

Health Care Provider	Name / Date	Health Care Provider	Name / Date
☐ Family Doctor		☐ Physical Therapist	
☐ Specialist		☐ Occupational Therapist	
☐ Psychiatrist/Psychologist		☐ Speech Therapist	
☐ Pain Clinic		☐ Chiropractor	

Therapist Comments: ☐ **Prior treatment reviewed**

***DIAGNOSTIC TEST(S): Have you had any of the following for your current condition? (If yes, please check and state results.)**

Test	Date / Result	Test	Date / Result
☐ None		☐ MRI	
☐ X-rays		☐ EMG	
☐CT scan		☐ Other	

Therapist Comments: ☐ **Prior tests reviewed.**

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***MEDICAL HISTORY:**

***Any past surgeries**? ☐No ☐Yes, please list and date:

(Please check each box that applies) ☐ **Reviewed with patient (Unremarkable)**

Have you had any of the following: ☐ None

☐Heart disease/attack	☐Lung disease/asthma	☐Stroke	☐Arthritis (type: ___________)
☐Pacemaker/defibrillator	☐Kidney disease	☐Head injury	☐Osteoporosis/osteopenia
☐High blood pressure	☐Liver disorder/hepatitis: ______	☐Headaches	☐Metal implants
☐Circulation problems	☐Thyroid disease	☐Seizures	☐Stomach disorders
☐Diabetes (type: ____________)	☐Skin disease	☐Dizziness	☐Frequent nausea/vomiting
☐Blood issues/history of clot	☐Cancer (type: ______________)	☐Swallowing problems	☐Bowel/bladder issues
☐HIV (+)	☐MRSA/VRE(+)	☐Mental health issues	☐Neuromuscular disease

☐ **Other medical history that we need to be aware of, i.e., accidents or other?** ☐ **None** ____________________________

Hearing loss: ☐No ☐Yes **Hearing aids**: ☐No ☐Yes **Glasses/Contact lens**: ☐No ☐Yes

Allergies to: ☐ Tape/Latex ☐Adhesive ☐Environmental ☐ Drug Type______________________________

Do you smoke? ☐No ☐Yes, how many packs/day:_____ **Do you drink alcohol?** ☐No ☐Yes, how much: ________________

Is there any chance you may be pregnant? ☐No ☐Yes, _____# of months

List all current medications including over-the-counter types *(If you have a list, we will photocopy it.): ☐ **None**

Therapist Comments:

***EMPLOYMENT:**

Are you currently working? ☐Full-time ☐Part-time ☐Retired ☐Disabled ☐Student ☐Unemployed

Occupation / Job Title / Responsibilities: ______________________________

List any restrictions:______________________________

What problems are you having at work due to your condition: ______________________________

List any hobbies: ______________________________

Therapist Comments: (Return to work goals: Industrial Rehab, disability, restrictions, lifestyle, hobbies, home life.)

PERSONAL INFORMATION/ACTIVITIES OF DAILY LIVING:

Home: ☐1-story with/without basement ☐2-story home with/without basement ☐Apartment with/without elevator ☐Mobile Home ☐Other:

Stairs: Maximum # of stairs in your home:_____

When going up the stairs, are handrails on the: ☐Left ☐Right ☐Both ☐None

Live(with): ☐Alone ☐Spouse ☐Friend(s) ☐Family

Therapist Comments:

Equipment: Assistive equipment used at home (lift chair, bathroom rails, etc): ☐ None ☐Yes, equipment used:__________________

Prior to the current problem, did you walk using a device? ☐No ☐Cane ☐Crutches ☐Standard Walker ☐Rolling Walker ☐Other:

Falls: Number of falls you have had in the last month/year? ☐ None ☐Yes (If yes, number of falls last month:_____/ last year:_____)

Needs: Do you have any additional needs? ☐No ☐Yes (If yes, please check all that apply)

☐Interpreter ☐Large Print ☐Nutrition Counsel ☐Counseling ☐Support Groups ☐Other:

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Please review the list below and rate those tasks that your condition affects using the scoring guide below.

Only rate those tasks that apply to you.

SCORING GUIDE

0=Able to perform at the same level as before injury or problem   0 1 2 3 4 5 6 7 8 9 10   **10**=Unable to perform activity

Please circle your responses below

TASKS	RATING (0-10)	THERAPIST COMMENTS
Sitting		
Standing		
Walking		
Running		
Stairs		
Balancing		
Kneeling		
Bending / Stooping		
Jumping / Hopping		
Sleeping		
Positional changes in bed		
Getting in/out of bed, chairs, car, etc.		
Driving including fastening seatbelt		
Housekeeping		
Yard work		
Job responsibilities including computer work		
Leisure tasks		
Pulling / Pushing / Reaching		
Lifting / Carrying		
Personal care (grooming, bathing, dressing, toileting, etc.)		
Gripping / Grasping		
Coordination (upper or lower body)		
Eating / Swallowing		
Speaking		
Understanding Speech		
Writing		
Reading		
Other:		
Other:		

ADDITIONAL COMMENTS: History reviewed with patient: ☐**Yes** ☐**No**

Patient's signature/date:	***Therapist(s) signature/date:**