SUBJECTIVE INFORMATION:

Name: __________________________ Date: _____/_____/_____ Age:_____ 

Was a prescription given to the front desk?  Y  N

Referring Physician: Name ______________________ph#__________________

Onset

Date of Onset/Date condition began: ______________ Onset Due to: ______________________

Symptoms: Primary Symptoms: ______________________ Related Symptoms: ______________________

Pain:

Pain Frequency: ______________________

Pain Quality (type: circle :) constant  intermittent  Dull  Sharp  Other

Pain Radiation (to where): _______________Pain Response to time of day: _______________ 

Pain Rating:

Verbal Pain rating at present (out of 10): 0= no pain, 10= worst pain imaginable_____/_____

Worst pain since onset: ___/___  Best pain since onset: ___/___

What makes your pain better? ___________________________  Worse? ___________________________
Is pain present at night (circle)? Yes No if yes, what position helps you to sleep? ______________

Prior Episodes of condition coming in for:

How many Episodes or Exacerbations: _____ Exacerbation Duration: _____ Exacerbation Frequency:

Prior Treatment for condition (circle)? Yes No IF yes, when and with what type of practitioner: i.e.) PT., O.T, chiropractor? ______________________________

General Health Questions/Medical history

Other health Services concurrently provided for this condition:
________________________________________________

Pre-existing conditions:
____________________________________________________

Current Medications: ____________________________________________

Surgery due to condition (Circle): Yes No, If yes, date: ______

Is condition related to an auto accident? Yes No, if yes, date: ______

Is condition related to non-work accident? Yes No, if yes, date: ______

Have you had injections for your condition? Yes No, if yes, date: ______

Prior Falls (circle)? Yes No If yes, date: ___________

Diagnostic Tests pertinent to your symptoms (Circle) and date:
MRI___________ CT scan_______ X-Ray________ Other: _______________

Prior Level of function before diagnosis or injury

Prior Level of Function relating to diagnosis or current injury:
__________________________________________

What activities in your daily life or work duties have been affected by your problem?
__________________________________________

______________

Employment History:

Are you currently working (circle)?    Yes   No  if no, how many total days of work Have you missed? ______

What type of work do u do? _____________________________

Are your work duties (circle)?   Full     Restricted   how many hours per week do you work? ______

LIFESTYLE:

Are you exercising at home or on own (circle)?    Yes   No  if yes, what type? _____________

Are you using heat or cold for condition (circle)?    Yes   No  if yes, what type? _____________

Are you wearing a sling or brace (circle)?    Yes   No  if yes, what type? _____________

Do you smoke (Circle)?    Yes   No  if yes, what type? _____________

What type of non-work activities are you involved in?
__________________________________________
When are you scheduled to see your Doctor again?
____________________________________

**Patient Goals of Therapy, what do u want to accomplish?**

What are your Functional Goals?
________________________________________________________

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services at Outreach Physical and Occupational Therapy and Speech Rehabilitation, PLLC.

Patient Signature: ______________________  Date: ____________________

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