AXIS PT

Orthopedic, Manual & Sports
Physical Therapy

SUBJECTIVE INFORMATION

Please check appropriate # on scale 0 = no pain 10 = severe

Pain scale ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

1. How do you **alleviate** your symptoms?_____
2. List any movement or activity which **aggravates** your pain. _____

_____

3. When did this injury start bothering you or date of injury? (Most **RECENT**) _____
4. Please check one: Is your injury ☐ work related, ☐ motor vehicle accident, ☐ recreational, ☐ other?
5. What was the SPECIFIC cause of injury or the series of events leading up to your visit today _____

_____

6. Describe how your symptoms change during day (i.e., better, same, worse, stiff)

   Morning _____ Mid-day _____ Evening _____
7. Do you wake up during the night because of pain? ☐ Yes If yes, how many times?____ ☐No
8. Age _____ 9. Occupation _____
10. Do you **exercise** and if so what do you do? _____

Medical History

11. Please check ALL that apply: ☐cancer, ☐cardiac condition, ☐pacemaker, ☐osteoporosis, ☐diabetes, ☐hypertension, ☐depression, ☐rheumatoid arthritis, ☐other_____

12. Do you have any metal plates or screws?	☐Yes	☐No
13. Are you pregnant?	☐Yes	☐No
14. Do your symptoms increase when you cough or sneeze?	☐Yes	☐No
15. Any significant, unexplained weight loss over the past 2-3 months?	☐Yes	☐No
16. Have you experienced any bowel or bladder problems?	☐Yes	☐No
17. Have you had X-rays or an MRI? **Date** _____	☐Yes	☐No
18. Do you experience any of the following?		
Headaches	☐Yes	☐No
Light-headedness	☐Yes	☐No
Nausea	☐Yes	☐No
Blurred vision	☐Yes	☐No
Numbness or tingling anywhere	☐Yes	☐No
Muscle cramping	☐Yes	☐No
19. Have you **ever taken** steroids or anti-coagulants?	☐Yes	☐No

20. List any medications that you are **currently** taking: _____

Past Medical History: Prior surgeries or **ANY** medical history _____

The above answers are correct to the best of my knowledge.

Name of patient or guardian _____

Signature of patient or guardian _____ Date _____

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