

Kinetic Chain Physical Therapy

Subjective Information Record

Date: _____ Name: _____ Age: _____

Date of Injury: _____ Occupation: _____

Are you currently working? Yes No Referring Doctor: _____

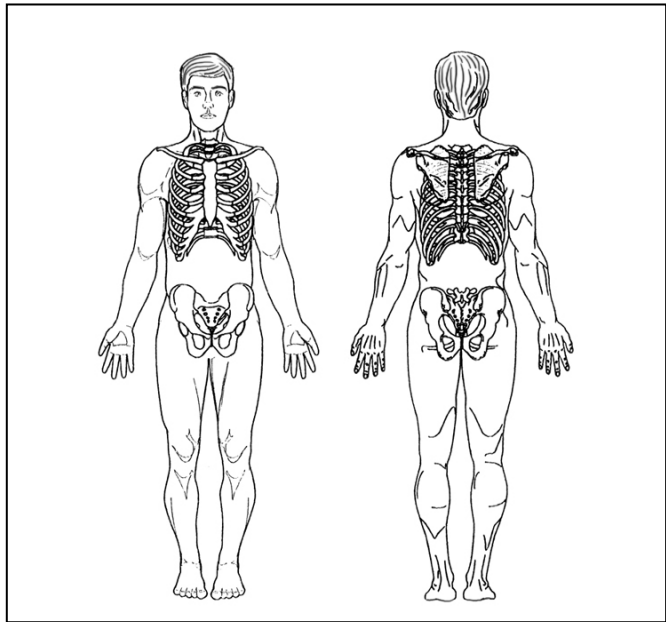
Height: _____ Weight: _____ Dominant Hand: (please circle) Right or Left

Present Injury:

1. Lightly draw in all areas of pain, stiffness, ache, etc., on the drawing to the right.
2. Label the spot of your worst pain.
3. Circle any areas of numbness or tingling.

When did this happen? _____

Where did the injury occur? _____



Was this due to an injury at home? _____ Yes _____ No

Was this due to an auto accident? _____ Yes _____ No

Is this a post-surgical condition? _____ Yes _____ No

Is this a pregnancy related condition? _____ Yes _____ No

Was this due to a recreational injury? _____ Yes _____ No

Did this happen due to no particular cause? _____ Yes _____ No

Was this due to an injury at work? _____ Yes _____ No

Was this due to a motor vehicle accident while at work? _____ Yes _____ No

Patient Name: _____

Behavior:

What activities or positions ease your symptoms?

- | | |
|--|---------------|
| _____ Doing exercises | _____ Sitting |
| _____ Heat or a hot shower | _____ Walking |
| _____ Ice | _____ Rest |
| _____ Lying on your back with knees up | |
| _____ Lying on side in fetal position | |

What activities make your pain worse (mark the worst 2-4 items from list)?

- | | | |
|----------------------------|-------------------------------|---------------------------|
| _____ Bend w/twist | _____ Housework | _____ Running |
| _____ Bending | _____ Getting in/out of bed | _____ Sitting |
| _____ Biting into an apple | _____ Getting in/out of car | _____ Sports |
| _____ Computer Work | _____ Going from sit to stand | _____ Squatting |
| _____ Coughing | _____ Lifting | _____ Turning head |
| _____ Deep breathing | _____ Looking down | _____ Walking |
| _____ Doing hair | _____ Looking up | _____ Walking down stairs |
| _____ Dressing | _____ Lying down | _____ Walking up stairs |
| _____ Driving | _____ Lying on stomach | _____ Yawning |
| _____ Eating | _____ Reaching | |

Check one of the following:

Do symptoms _____ increase _____ decrease or _____ stay the same by the end of the day?

When did you first see a Doctor? _____ Dr's Name: _____

Have you had any treatment for this so far? Yes No If yes, please explain: _____

List any other Drs. seen for this problem and what treatment was provided:

1. _____
2. _____

Patient Name: _____

Have you had any of the following for this injury?:

Brace Cast CT Scan EMG Injection MRI Surgery Xray None of the above

What most describes your symptoms: _____Constant _____Intermittent (comes and goes)

If your symptoms are intermittent, how often do you get them? Check one:

_____Daily _____1-2 times/week _____3-5 times/week

How do you describe your symptoms? Check all that apply:

_____Stiffness _____Ache _____Heaviness _____Shooting Pain
_____Numbness/Tingling

On a scale of 0-10, with 10 being the worst pain imaginable and 0 being no pain, where are you on the following scale?

0-----2-----4-----6-----8-----10

Do you get headaches? _____Yes _____No

If yes, how many times per week? _____Times/week

Do you feel your symptoms are **decreasing**, **increasing**, or **staying the same**?

History:

What medications are you now taking?: _____

Are you pregnant? _____Yes _____No _____Possibly

Do you have any metal implants? _____Yes _____No

Do you have or have you ever had, any of the following: (please circle all that apply)

Allergies Asthma Cancer Cardiac Problems Diabetes Osteoporosis
High Blood Pressure Pacemaker Respiratory Problems Seizures Dizziness

Describe **any** previous surgeries, injuries, or illness (**related** or **unrelated** to your present injury)

Please include dates:

1. _____
2. _____

Patient Signature: _____ Date: _____

Patient Name: _____