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# Therapy Subjective

Please answer every question

**STAFF:** Handwritten items must be entered **MANUALLY**.
Do not fold this form.

**Marking Instructions**

Please use black ink. Fill in the complete oval as shown.

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH: Month / Day / Year

AGE

**Hand dominance:** ◯ right ◯ left ◯ ambidextrous

## WORK HISTORY

**Are you currently working?** ◯ yes ◯ no ◯ retired ◯ student

**Is this a work related injury?** ◯ yes ◯ no

**Occupation:** ______________________________

## ONSET OF SYMPTOMS

◯ injury
◯ surgery
◯ gradual onset
◯ sudden onset
**other:** ____________

## SETTING

◯ at work
◯ at school
◯ at home
◯ accident
◯ athletic activities
◯ recreational activities
◯ motor vehicle accident
**other:** ____________

## EVENT

◯ altercation
◯ bending
◯ direct blow
◯ fall
◯ insidious onset
◯ lifting
◯ pulling
◯ reaching
◯ repetitive motion
◯ twisting
**other:** ____________

## SYMPTOMS

◯ buckling
◯ catching
◯ discomfort
◯ locking
◯ motion loss
◯ numbness
◯ pain
◯ stiffness
◯ swelling
◯ tingling
◯ weakness
**other:** ____________

## TIMING

◯ constant
◯ intermittent
◯ occasional
◯ rare
◯ daytime
◯ night time

## QUALITY

◯ sharp
◯ dull
◯ burning
◯ aching
◯ stinging
◯ throbbing
◯ stabbing
**other:** ____________

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SAMPLE

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# Therapy Subjective

Please answer every question

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## PAIN

**Are you currently experiencing pain?** ◯ yes ◯ no

**0 = no pain** **10 = intolerable**

**How much pain are you experiencing now?** ☺ ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ☹

**What is your pain level at its worst?** ☺ ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ☹

**What is your pain level at its least?** ☺ ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ☹

## EXACERBATING FACTORS

- ◯ **NONE**
- ◯ at rest
- ◯ extension
- ◯ flexion
- ◯ gripping
- ◯ in motion
- ◯ kneeling
- ◯ lifting
- ◯ reaching
- ◯ repetitive motion
- ◯ rotation
- ◯ sitting
- ◯ sleeping
- ◯ stairs
- ◯ standing
- ◯ squatting
- ◯ walking
- ◯ weightbearing

**other:** ________________

________________

**When are your symptoms at their worst?**

- ◯ all day
- ◯ as the day progresses
- ◯ in the afternoon
- ◯ in the evening
- ◯ in the morning
- ◯ overnight

**other:** ________________

## RELIEVING FACTORS

- ◯ **NONE**
- ◯ brace use
- ◯ chiropractor
- ◯ climbing stairs
- ◯ elevation
- ◯ extension
- ◯ flexion
- ◯ gripping
- ◯ heat
- ◯ ice
- ◯ in motion
- ◯ injections
- ◯ lifting
- ◯ lying down
- ◯ massage
- ◯ OTC medications
- ◯ previous surgery
- ◯ repetitive motion
- ◯ rest
- ◯ rotation
- ◯ Rx medications
- ◯ sitting
- ◯ splint use
- ◯ standing
- ◯ stretching
- ◯ walking

**other:** ________________

**When are your symptoms better?**

- ◯ all day
- ◯ in the morning
- ◯ in the afternoon
- ◯ in the evening
- ◯ overnight
- ◯ as the day progresses

**other:** ________________

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