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| C:\Users\Ro\Desktop\Wholisticpt.co\SmallWhole.png | WholisticPT1866 Harrier AvenueClermont, Florida, 34711954-802-6330 |

**MEDICAL HISTORY/SUBJECTIVE REPORT**

Please take a few minutes to fill out this survey.

## Personal Information

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| First Name | Last Name | Gender | Age |
|  |  |  |  |
| Address | City | State | ZIP Code |
|  |  |  |  |
| Email | Phone |  |  |

## The reason why you are seeking Myofascial release Therapy

### Check all that apply

[ ]  Reducing pain level [ ]  Post-Surgical Scar adhesions [ ]  Improving Function

[ ]  Increase Mobility [ ]  Improving posture [ ]  Greater wellness

|  |  |
| --- | --- |
| Other |  |

### Please shade areas of pain on the diagram below:



## Pain measure

### My pain is:

[ ]  Constant [ ]  Intermittent (comes and goes) [ ]  Sporadic

[ ]  Changes depending on activity [ ]  Changes depending on the time of the day

|  |  |
| --- | --- |
| Other |  |

### Please check and choose the appropriate number

[ ]  0 no pain

[ ]  1 You are pretty aware of pain but it allows you to continue with activities

[ ]  2 Pain makes you stop the activity

[ ]  3 Very intense (cold sweats, nausea, shakiness)

[ ]  4 Needs help immediately, ER or in your way to ER

### How long have you been experiencing symptoms?

|  |
| --- |
|  |
| How did the pain start? |
|  |

### Since onset your pain is

[ ]  Better [ ]  Worse [ ]  The same

## How would you describe your pain

### Check all that apply

[ ]  Sharp [ ]  Dull/ache [ ]  Burning

[ ]  Shooting [ ]  Tightness [ ]  Pressure

[ ]  Cramping [ ]  Spasms

|  |  |
| --- | --- |
| Other |  |

|  |
| --- |
| What activities aggravate the pain? |
|  |
| Is there anything that gives relieve? (Heat, cold, stretch, rest, etc.) |
|  |
| Are you using any pain medication? |
|  |
| Have you been treated for the same condition/complaint? If so, please explain in what kind of treatment. |
|  |
| Any other information that you feel your therapist should know |
|  |

## Past medical record

|  |
| --- |
| List all medical conditions that you have had in the past or present |
|  |
| List all surgeries you have had (include cosmetic procedures) |
|  |
| List all medication you are currently taking (include over the counter) |
|  |
| List any traumas major and minor (falls, accidents, etc.) that you recall |
|  |
| Are you under stress normally? |
|  |
| Have you recently experienced a major life stressor? If yes, please explain. |
|  |
| What are your goals for therapy? |
|  |

**\*\*It is the patient's responsibility to inform and keep the therapist inform or any and all changes regarding medical status.**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Name  | Date |  |  |
|  |  |  |  |
| Patient signature |  |  |  |
|  |  |  |

Therapist signature Date

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |