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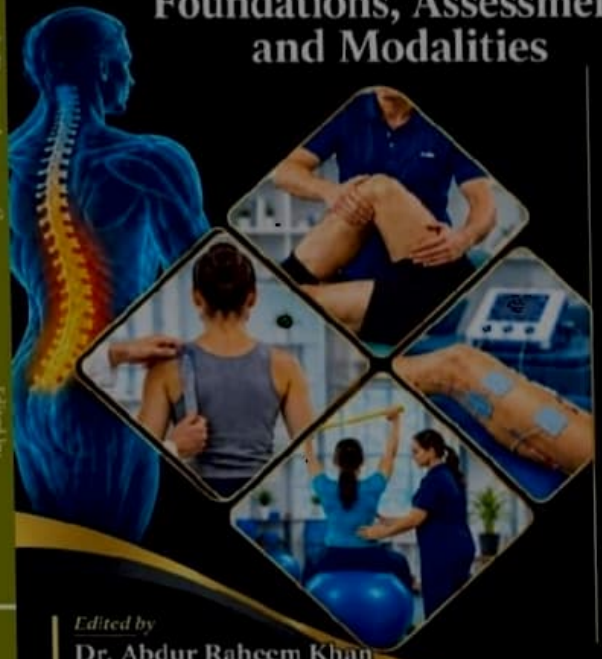
Principles and Practices of Physiotherapy

Edited by
Dr. Abdur Raheem Khan
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Principles and Practice *of* Physiotherapy:

Foundations, Assessment, and Modalities



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FUNCTIONAL REHABILITATION

Edited by

Dr. Abdur Raheem Khan
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CHAPTER 10

CLINICAL HISTORY TAKING AND SUBJECTIVE EXAMINATION

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Abstract

History taking and subjective examination are central to patient assessment because they establish the patient's reason for seeking care, describe the evolution of symptoms, identify relevant risks, and provide the context needed for physical examination and clinical decision-making. This chapter presents an organised approach to obtaining subjective data through patient-centred communication and systematic questioning. It covers preparation for the interview, identification and presenting concern, history of the present illness, past medical and surgical history, medication and allergy review, family and social history, review of systems, pain and functional assessment, and psychosocial considerations. The chapter also explains how open-ended questions, active listening, clarification, summarising, and appropriately focused closed questions improve the quality of the interview. Subjective findings should be interpreted as part of clinical reasoning rather than recorded as an isolated list of symptoms. Accurate documentation, recognition of red flags, respect for privacy, cultural responsiveness, and confirmation of the patient's understanding are essential for safe care. When the interview is combined with objective examination and appropriate investigations, it supports differential diagnosis, individualized care planning, continuity of care, and shared decision-making.

Keywords: patient assessment; history taking; subjective examination; clinical reasoning; therapeutic communication.

1. Introduction

Patient assessment is a systematic process that involves gathering, interpreting, and documenting relevant information about an individual's health status. The history is mainly obtained through interaction with the patient and covers their presenting symptoms, personal experiences, concerns, functional difficulties, past medical conditions, previous treatments, and social background. Rather than