

PATIENT MEDICAL HISTORY

To ensure you receive a complete and thorough evaluation, please provide your therapist with the following information to the best of your ability.

DATE: _____ NAME: _____ Date of Birth: _____

How did you hear about Rehab Etc.? _____

Please describe how your **CURRENT** symptoms began (i.e. bending, lifting, accident, not sure, etc):

Are your symptoms the result of a work injury or a motor vehicle accident? Yes No

If Yes, Please explain: _____

Have you contacted a lawyer regarding your symptoms/injury? Yes No

If Yes, who have you contacted? _____

When did your **CURRENT** symptoms begin? _____

What is your occupation? _____

What types of activities do you perform at work? _____

Are you on restricted duty or off work as a result of your symptoms or injury? Yes No

If Yes, please explain: _____

Please list what activities, positions, or other factors increase your symptoms. _____

Please list factors that decrease your symptoms: _____

Please list the special tests or radiology you have had with results. _____

Place a mark on the line indicating your current pain rating (0 = No Pain, 10 = Emergency Room Pain)

0 _____ **10**

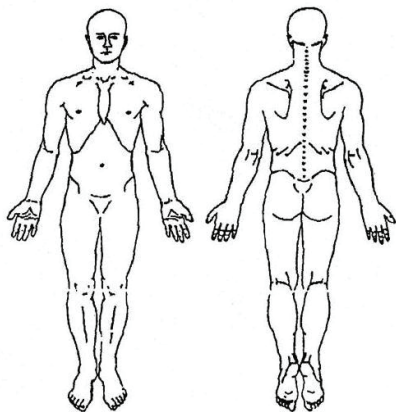
Rate your pain out of 10

_____/10 Symptoms at their best

_____/10 Symptoms at their worst

Please use the following symbols on the diagram below to indicate the type and location of your symptoms.

Pain: XXXX Numbness: ///// Tingling: OOOOO



Please check any of the following that describes your pain:

- _____ Constant _____ Intermittent

_____ Sharp _____ Dull

_____ Improving _____ Worsening

_____ Disturbs sleep _____ Increases with cough/sneeze

Have you ever been diagnosed with any of the following conditions?

- | | | |
|---|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Other arthritic conditions | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> Other _____ | |

List any RECENT or MAJOR surgeries including the date.

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

List prescription or over the counter medication, as well as vitamins/supplements you are taking.

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

List any drug allergies you are aware of: _____

Are you allergic to latex? YES NO

Do you smoke or use other tobacco products? YES NO
If yes, how much per day? _____ For how long? _____

If you drink alcohol, about how many drinks do you consume, on average, per week? _____

Please check any of the following that you have experienced:

- | | | |
|---|--|---|
| <input type="checkbox"/> rapid weight loss/gain | <input type="checkbox"/> swelling | <input type="checkbox"/> nausea/vomiting |
| <input type="checkbox"/> easy bruising | <input type="checkbox"/> dizziness or balance problems | <input type="checkbox"/> excessive bleeding |
| <input type="checkbox"/> excessive fatigue | <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> unusual weakness |
| <input type="checkbox"/> persistent cough | <input type="checkbox"/> fever/chills/night sweats | <input type="checkbox"/> numbness/tingling |
| <input type="checkbox"/> rapid heartbeat | <input type="checkbox"/> tremors | <input type="checkbox"/> difficulty swallowing |
| <input type="checkbox"/> seizures | <input type="checkbox"/> heartburn/indigestion | <input type="checkbox"/> double vision |
| <input type="checkbox"/> constipation/diarrhea | <input type="checkbox"/> problems with vision | <input type="checkbox"/> blood in stools or urine |
| <input type="checkbox"/> unusual eye redness | <input type="checkbox"/> post-menopausal | <input type="checkbox"/> skin rash |
| <input type="checkbox"/> difficulty urinating | <input type="checkbox"/> difficulty sleeping | <input type="checkbox"/> urinary incontinence |
| <input type="checkbox"/> sexual difficulties | <input type="checkbox"/> pregnant | <input type="checkbox"/> difficulty hearing |
| <input type="checkbox"/> head aches | <input type="checkbox"/> pain which does not improve at rest | |

Patient signature: _____ Date: _____

Therapist signature: _____ Date: _____