

PATIENT MEDICAL HISTORY



Name: _____ Referring Physician: _____

Date of 1st Dr. visit for this injury: _____ Next Dr. Appointment: _____

Last date worked for this injury: _____ Date returned to work: _____

Family Physician: _____

Is an attorney involved in this case? Yes No Have you had surgery for this injury? Yes No

Type of surgery: _____ Number of surgeries: _____

Are you currently taking any medications? Yes No

_____ Anti-inflammatories List Medications: _____
_____ Muscle Relaxers _____
_____ Pain Medication _____

Have you had any of the following Medical or Rehabilitative Services for this injury / episode?

_____ Chiropractor _____ CT Scan
_____ EMG / NCV _____ General Practitioner
_____ Massage Therapy _____ MRI
_____ Myelogram _____ Neurologist
_____ Occupational Therapy _____ Orthopedist
_____ Physical Therapy _____ Podiatrist
_____ Emergency Room Care _____ X-rays
_____ Other: _____

Do you have or have you ever had any of the following?

_____ Asthma/ Bronchitis/ Emphysema _____ Severe or frequent Headaches
_____ Shortness of Breath/ Chest Pain/ Angina _____ Vision or Hearing Difficulties
_____ Coronary Heart Disease/ Pacemaker _____ Numbness or Tingling
_____ Heart Attack/ Surgery _____ Dizziness or Fainting
_____ High Blood Pressure _____ Weakness
_____ Stroke/ TIA _____ Arthritis/Swollen Joints
_____ Blood Clot/ Emboli _____ Hernia
_____ Gout _____ Varicose Veins
_____ Epilepsy/ Seizures _____ Allergies: _____
_____ Thyroid Trouble/ Goiter _____ Any Pins or Metal Implants
_____ Osteoporosis _____ Joint Replacement
_____ Infectious Diseases _____ Currently Pregnant
_____ Diabetes _____ Emotional/Psychological Problems
_____ Cancer/ Chemotherapy/ Radiation _____ Bowel/ Bladder Problems
_____ High Cholesterol _____ Family history of heart disease

Do you currently smoke? Yes No Do you currently exercise 3-5 times per week? Yes No
List any other information that would assist us in your care: _____

Pain Rating Today: 0 1 2 3 4 5 6 7 8 9 10
No Pain Strong Hospitalized

Are you aware of your Diagnosis? Yes No Expectations from Therapy: _____

Would you like to speak to a social worker about any aspect of your rehabilitation program? Yes No

Patient/ Guardian Signature: _____ **Date:** _____

