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
_____ Muscle Relaxers
_____ Pain Medication

List Medications: _____
_____
_____

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

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

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

_____ Asthma/ Bronchitis/ Emphysema
_____ Shortness of Breath/ Chest Pain/ Angina
_____ Coronary Heart Disease/ Pacemaker
_____ Heart Attack/ Surgery
_____ High Blood Pressure
_____ Stroke/ TIA
_____ Blood Clot/ Emboli
_____ Gout
_____ Epilepsy/ Seizures
_____ Thyroid Trouble/ Goiter
_____ Osteoporosis
_____ Infectious Diseases
_____ Diabetes
_____ Cancer/ Chemotherapy/ Radiation
_____ High Cholesterol
_____ Severe or frequent Headaches
_____ Vision or Hearing Difficulties
_____ Numbness or Tingling
_____ Dizziness or Fainting
_____ Weakness
_____ Arthritis/Swollen Joints
_____ Hernia
_____ Varicose Veins
_____ Allergies: _____
_____ Any Pins or Metal Implants
_____ Joint Replacement
_____ Currently Pregnant
_____ Emotional/Psychological Problems
_____ Bowel/ Bladder Problems
_____ 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** (No Pain) **1** **2** **3** **4** **5** (Strong) **6** **7** **8** **9** **10** (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:** _____