Medical History and Rehab Information **Date:**

Patient Name		**Date of Birth:**	**Age:**
Chief Complaint		**Date of Symptom Onset or Injury**	

Is the Reason for Therapy Accident Related? ☐ No ☐ Yes If yes, please check one: ☐ Accident ☐ Auto ☐ Work ☐ Other If Other, please explain:
If you are employed, please list some of your job duties/expectations:
Are you currently receiving any other care for the condition mentioned above? ☐ No ☐ Yes If yes, please explain:
Have you ever received therapy in the past for the condition mentioned above? ☐ No ☐ Yes If yes, please explain: Recent x-rays or other diagnostic tests? ☐ No ☐ Yes If yes, please explain:
Have you received therapy services for other problems/conditions during this calendar year? ☐ No ☐ Yes If yes, please list:

Current Medications:	Allergies:
Previous Surgeries:	Previous Fractures:

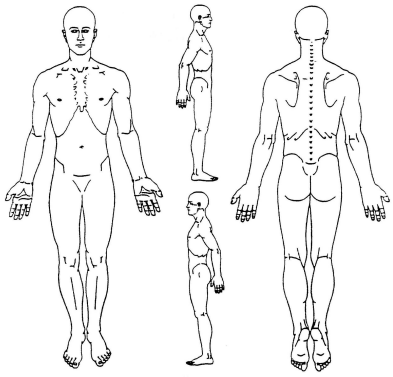
Do you now have or have you ever had any of the following conditions? (check all that apply)

☐ Difficulty Swallowing	☐ Motion Sickness	☐ Stroke	☐ Arthritis	☐ Epilepsy/Seizure
☐ Fever/Chills/Sweats	☐ Anemia	☐ Diabetes	☐ Fibromyalgia	☐ Osteoporosis/Osteopenia
☐ High Blood Pressure	☐ Blood Clots	☐ Hepatitis	☐ Pregnancy	☐ Depression
☐ Heart Trouble	☐ Pacemaker/Defibrillator	☐ Pain	☐ Cancer	☐ Swelling/Edema
☐ Unexplained Weight Loss	☐ Shortness of Breath	☐ HIV	☐ Headaches	☐ History of Drug Abuse
☐ Joint Replacement(s)	☐ Incontinence	☐ Constipation	☐ Neuropathy	☐ Dizziness/Vertigo
☐ Parkinson's Disease	Other: _____			

Do you have trouble performing or are you unable to perform any of these tasks? (check all that apply)

☐ Getting into/out of bed	☐ Eating	☐ Getting into/out of chair	☐ Sitting	☐ Writing
☐ Walking up/down stairs	☐ Walking	☐ Work related activities	☐ Standing	☐ Dressing
☐ Bathing/Showering	☐ Doing Laundry	☐ Vacuuming	☐ Cooking	☐ Shopping
☐ Getting into/out of shower	☐ Cleaning	☐ Brushing your teeth	☐ Sleeping	
☐ Getting into/out of car	☐ Driving	☐ Personal Hygiene activities	☐ Communicating	

Other: _____



IF YOU ARE HAVING PAIN **Rate your pain** (0=no pain,10=extreme,unbearable pain).

Currently: 0 1 2 3 4 5 6 7 8 9 10

At its worst: 0 1 2 3 4 5 6 7 8 9 10

At its best: 0 1 2 3 4 5 6 7 8 9 10

Mark the areas of your pain or discomfort on the body diagrams.

Describe your pain: sharp/dull, numbness, aching, burning, tingling, other _____

What makes your pain worse?_____

What makes your pain better? _____

Does the pain radiate to other areas? ☐ No ☐ Yes If yes, please explain: