Name_____ DOB: _____ Date _____

Rehab Patient History Form

Occupation_____ Referring Doctor_____ Diagnosis from Doctor_____

Social History *(circle all that apply)*:

I live: Alone With Someone That Can Help Someone That Can Help Lives Nearby I'm A Caregiver

My home is: Single Level Multi-level Has Stairs to Enter

Other living situation concerns? _____

What is your normal activity level *(circle)*: Sedentary Light Moderate Heavy Very Heavy

What sports/exercises do you participate in?

_____

How frequently? _____ For what duration?_____minutes/hours

I am: ☐ Right handed ☐ Left handed ☐ Ambidextrous

General Medical History: Have you ever been told you have any of the follow? (*Check all that apply*):

☐ Asthma	☐ Hepatitis	☐ Pacemaker
☐ Anxiety/Depression	☐ High blood pressure	☐ Rheumatoid arthritis
☐ Brain injury	☐ Infection disease	☐ Seizures/Epilepsy
☐ Cancer	☐ Kidney disease	☐ Stroke
☐ Diabetes	☐ Lung problems	☐ Thyroid problems
☐ Fibromyalgia	☐ Osteoarthritis	☐ Ulcers
☐ Heart problems	☐ Osteoporosis	☐ Other _____

Currently, are you experiencing any of the following? (*Check all that apply*):

☐ Changes in appetite	☐ Dizziness	☐ Nausea/vomiting
☐ Changes in bowel/bladder	☐ Fever/chills/sweats	☐ Pelvic pain
☐ Depression	☐ Headaches	☐ Poor balance (falls)
☐ Diabetes	☐ Night pain	☐ Shortness of breath
☐ Difficulty swallowing	☐ Numbness/tingling	☐ Unexplained weight loss

Current History:

What brings you to therapy?

_____

_____

_____

Date your injury/symptoms started? _____ Surgery date (if applicable)? _____

Activities/postions that make you feel *worse*?

_____

_____

_____

Activites/positions that make you feel *better*?

_____

_____

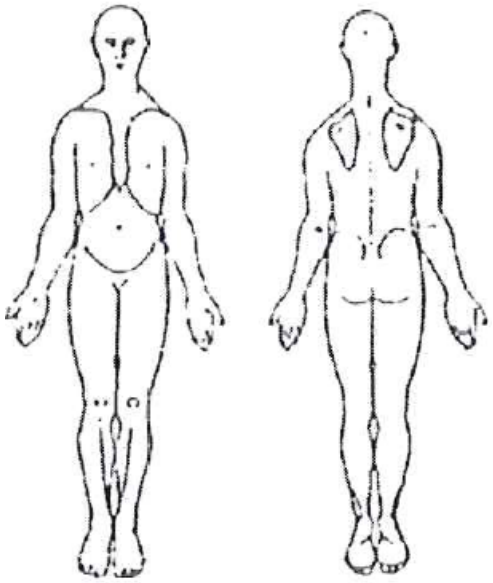
_____

Is your condition/problem? ☐ Getting better ☐ Staying the same ☐ Getting worse

DRAW on the diagram below the specific areas of pain, numbness or tingling; if pain travels draw arrows

RATE your pain level at this time *(circle a number)*

No pain 0 1 2 3 4 5 6 7 8 9 10 *Severe pain*



DESCRIBE your pain/symptoms *(circle all that apply)*

Burning Cramp Deep ache Dull ache

Numbness Sharp Stabbing Sore

Throbbing Tingling Twinge

Other _____

My symptoms are: ☐ Constant ☐ Intermittent

Have you had any treatment for this problem? If yes, please describe the result (did it help?):

_____

_____

_____

List any tests you have had related to this problem *and their results* (x-rays, MRI, etc):

_____

_____

_____

Surgical/Procedural History (Current and Past); Please include approximate date:

_____ _____

_____ _____

_____ _____

_____ _____

List any medications (prescription and over-the-counter) you are currently taking and reason:

☐ *See Electronic Medical Record* ☐ *See attached list*

Medication	Reason	Medication	Reason

List 3 goals you have for therapy. *Be specific!* ***Also circle your current ability to do each goal/task where 0 is unable to perform activity and 10 is able to perform activity at same level as before injury/problem***

Goal: *ie. Improve sleep, return to sport/exercise, dress easier, sit/stand longer*	**Current Ability (circle):**
1. _____	0 1 2 3 4 5 6 7 8 9 10
2. _____	0 1 2 3 4 5 6 7 8 9 10
3. _____	0 1 2 3 4 5 6 7 8 9 10