

NAME: _____ AGE: _____ DATE OF NEXT DOCTOR'S APPOINTMENT: _____ @ _____

ARE YOU PRESENTLY WORKING? YES NO IF YES: LIGHT DUTY REGULAR DUTY

ARE YOU RIGHT or LEFT HANDED? ARE YOU PREGNANT? YES NO

WHICH AREA IS THE PROBLEM? HEADACHES TMJ NECK UPPER BACK LOW BACK
(RIGHT or LEFT) SHOULDER ELBOW WRIST HAND FINGER HIP KNEE ANKLE
 FOOT TOE OTHER: _____

HOW DID THIS PROBLEM BEGIN?

LIFTING TWISTING FALLING CRUSHING MOTOR VEHICLE ACCIDENT UNKNOWN

DATE OF INJURY OR WHEN PROBLEM FIRST OCCURRED: _____

WAS THE ONSET: GRADUAL or SUDDEN?

IF YOU HAVE HAD THIS PROBLEM FOR A LONG TIME, WHEN DID IT RECENTLY BECOME WORSE: _____

ARE YOU CURRENTLY BEING SEEN BY ANY OF THE FOLLOWING:

MEDICAL DOCTOR PHYSICAL/OCCUPATIONAL THERAPIST DENTIST
 PSYCHIATRIST/PSYCHOLOGIST OSTEOPATH CHIROPRACTOR

WHAT REASON: _____

HAVE YOU BEEN HOSPITALIZED FOR THIS PROBLEM? YES NO IF YES DATES: _____

HAVE YOU HAD ANY OF THE FOLLOWING TESTS FOR THIS CONDITION? IF YES, GIVE DATES:

XRAYS _____ MRI _____ CT SCAN _____ BONE SCAN _____ OTHER _____ NONE: _____

LIST ANY SURGERIES (IN/OUT PATIENT) AND ANY CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED:

DATE	REASON
_____	_____
_____	_____
_____	_____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING?

YES	NO	YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HAS SOMEONE THREATENED OR HARMED YOU? YES NO

HAVE YOU EVER HAD ANY THOUGHTS OF HARMING YOURSELF? YES NO

HAVE YOU EVER HAD A FRACTURE OR DISLOCATION? YES NO

IF YES, WHICH BODY PART: _____ DATE _____

DO YOU HAVE ANY OF THE FOLLOWING METALS OR PLASTICS IN YOUR BODY?

RODS PINS PLATES STAPLES ARTIFICIAL JOINTS METAL FROM GUNSHOT WOUND NONE
LOCATION: _____

LIST ANY CURRENT MEDICATIONS OR RECENT INJECTIONS: _____

DRUG ALLERGIES: _____

SIGNATURE: _____ DATE: _____ If other than patient, relationship: _____

REVIEWED BY THERAPIST: _____ DATE: _____

PATIENT IDENTIFICATION



**REHAB SERVICES
PATIENT MEDICAL HISTORY**