PATIENT MEDICAL HISTORY

Name: _____ Referring Physician: _____
Family Physician: _____ Date of first Doctor Visit for this injury: _____
Last date worked due to this injury: _____ Date returned to work after this injury: _____
Is an Attorney involved in this case? **__Y __N**
Have you had surgery for this injury? **__Y __ N** Number of Surgeries**: 1 2 3 4 _____**
Type of Surgery: _____ Took place in: **____hospital ____ Surgery Center**

Are you currently taking any prescription or non-prescription medications? **___Y ____N**

___Anti-inflammatory ___Muscle Relaxers ___Pain Medications
List Medications: _____

Are you allergic to any Medications? **____Y ____N List Medications: _____**

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

Chiropractor	**__Y**	**__N**	CT scan	**__Y**	**__N**
EMG/Therapy	**__Y**	**__N**	General Practitioner	**__Y**	**__N**
Massage Therapy	**__Y**	**__N**	MRI	**__Y**	**__N**
Myelogram	**__Y**	**__N**	Neurologist	**__Y**	**__N**
Occupational Therapy	**__Y**	**__N**	Orthopedist	**__Y**	**__N**
Physical Therapy	**__Y**	**__N**	Podiatrist	**__Y**	**__N**
Emergency Room Care	**__Y**	**__N**	X-rays	**__Y**	**__N**

Other: _____

Do you have, or have you ever had ANY of the following?

Asthma, Bronchitis, or Emphysema	**__Y**	**__N**	Severe or Frequent Headaches	**__Y**	**__N**
Shortness of Breath/Chest Pain	**__Y**	**__N**	Vision or Hearing Difficulties	**__Y**	**__N**
Coronary Heart Disease or Angina	**__Y**	**__N**	Numbness or Tingling	**__Y**	**__N**
Do you have a Pacemaker?	**__Y**	**__N**	Dizziness or Fainting	**__Y**	**__N**
High Blood Pressure	**__Y**	**__N**	Bowel or Bladder Problems	**__Y**	**__N**
Heart Attack or Surgery	**__Y**	**__N**	Weakness	**__Y**	**__N**
Stroke/TIA	**__Y**	**__N**	Weight Loss/Energy Loss	**__Y**	**__N**
Congestive Heart Disease	**__Y**	**__N**	Hernia	**__Y**	**__N**
Blood Clot	**__Y**	**__N**	Varicose Veins	**__Y**	**__N**
Epilepsy/Seizures	**__Y**	**__N**	Allergies **__Y**	**__N**	
Thyroid Disease or Goiter	**__Y**	**__N**	Any Pins or Metal Implants	**__Y**	**__N**
Anemia	**__Y**	**__N**	Joint Replacement Surgery	**__Y**	**__N**
Infectious Diseases	**__Y**	**__N**	Neck Injury/Surgery	**__Y**	**__N**
Diabetes	**__Y**	**__N**	Shoulder Injury	**__Y**	**__N**
Cancer or Chemotherapy/Radiation	**__Y**	**__N**	Elbow/Hand Injury/Surgery	**__Y**	**__N**
Arthritis	**__Y**	**__N**	Back Injury/Surgery	**__Y**	**__N**
Osteoporosis	**__Y**	**__N**	Knee Injury/ Surgery	**__Y**	**__N**
Gout	**__Y**	**__N**	Leg/Ankle/Foot Injury/Surgery	**__Y**	**__N**
Sleeping Problems/Difficulties	**__Y**	**__N**	Are you pregnant	**__Y**	**__N**
Emotional/Psychological Problems	**__Y**	**__N**	Do you use Tobacco?	**__Y**	**__N**

List any other information that would assist us in your care: _____
_____

Are you aware of your diagnosis and prognosis as explained by your doctor? **__Y __N**
Based on your awareness, what are your rehabilitations expectations/goals while in this program?
_____

Would you like to speak to a social worker about any aspects of you rehabilitation program? **__Y __N**

Patient/Guardian Signature: _____ Date: _____