

Print Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Have you ever had the following conditions? (Please check)

Condition	Yes	No
Heart trouble		
High blood pressure		
Diabetes		
Headaches		
Dizzy spells		
Fainting spells		
Epilepsy		
Stroke		
Pregnant		

Condition	Yes	No
Asthma		
Emphysema		
Back injury		
Arthritis		
Bleeding disorder		
Fracture		
Cancer		
Pacemaker		
Other:		

**Regarding your present injury / condition:**

Date of injury / condition: \_\_\_\_\_

How did the injury occur? \_\_\_\_\_

Have you been hospitalized for the present problem?  Yes  No

Have you had surgery for the present problem?  Yes  No

Have you had therapy for current problem?  Yes  No If so, please summarize the results: \_\_\_\_\_

Last seen by physician for present problem on \_\_\_\_\_ (date) Next appointment scheduled on \_\_\_\_\_ (date)

Are you being seen by any other physician?  Yes  No \_\_\_\_\_

Allergies  Yes  No If yes, list \_\_\_\_\_

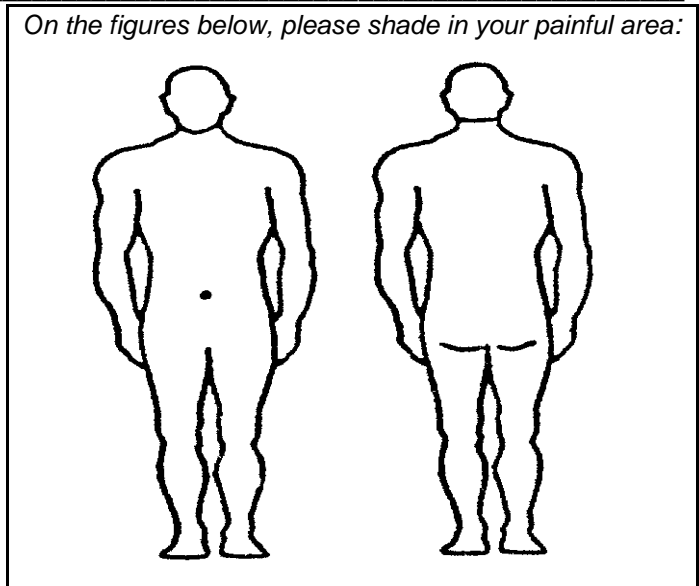
Are you on medication:  Yes  No If yes, list type of medication (including over-the-counter medications, herbal supplements and vitamins): \_\_\_\_\_

Which of the following best describes your symptoms (check those that are appropriate)?

- Sharp  Dull  Burning  Numbness
- Constant  Intermittent  Pins and needles
- Other: \_\_\_\_\_

Using a scale of 0 – 10, please rate your pain (0 being no pain, 10 being the most pain): \_\_\_\_\_

What are the goals you would like to achieve through therapy?  
\_\_\_\_\_  
\_\_\_\_\_



Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**LABEL:**

**REHABILITATIVE SERVICES –  
PAST MEDICAL HISTORY**