

Pro-Rehab Services

Physical Therapy and Rehabilitation Center

NEW PATIENT MEDICAL HISTORY INFORMATION

Please answer the following questions about your medical history.

1) Patient Name _____ Date of Birth _____

2) What Problems are you being treated for today? _____

3) When did your problem/s begin? _____

4) How did your problem/s begin? _____

5) Have you had any surgeries related to this problem? Yes No .

6) If Yes, Type of surgery and Date _____

7) Have you received treatment of these symptoms? Yes No

8) Have your received outpatient Physical Therapy for this condition? Yes No

9) Are your currently receiving Home Health Care Services? Yes No

(You cannot receive home health care services and outpatient therapy services concurrently under Medicare rules)

10) If yes, Name of Agency _____ Phone No. _____

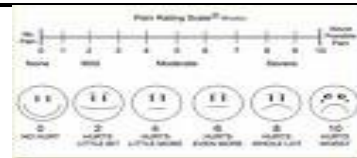
11) Are you currently working? Yes No

12) If you are working, what is your occupation? _____

13) Does your occupation consist of: Sitting Standing Walking Lifting Driving

14) Are you currently taking any medications? Yes No

If yes, please list medications _____



15) If you have pain, what is the current level of pain?

16) Do you have any known allergies to drugs? Yes No . If yes, please list your allergies

17) What kind of diagnostic tests, if any, have you had for this problem?

X-ray MRI Bone Scan CT Scan Blood Tests

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18) Please CHECK the boxes next to any conditions that you have experienced in the past. CIRCLE any conditions that you have currently

- | | | |
|---|--|---|
| <input type="checkbox"/> Bone and joint disease | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Tendonitis /bursitis | <input type="checkbox"/> Lymph edema | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Metal Implants |
| <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Herpes/shingles | <input type="checkbox"/> Are you pregnant? |
| <input type="checkbox"/> Sprains/ strains | <input type="checkbox"/> Sleep Disorders | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Low back, hip, leg pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Athlete's foot |
| <input type="checkbox"/> Neck, shoulder, arm pain | <input type="checkbox"/> Psychological issues | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Headaches/head injuries | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Bladder problems |
| <input type="checkbox"/> Cancer/tumors | <input type="checkbox"/> Drug/alcohol addiction | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Nicotine/caffeine addiction | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Heart conditions | <input type="checkbox"/> Breathing difficulties/asthma | <input type="checkbox"/> Chest pain |

If you checked/ circled any of the above, please give any available details:

19) Is there any additional information that we should be aware of to make your rehabilitation easier?

20) What is your goal in therapy?

21) What is your living condition? Do you live alone?

Patient Signature

Date