# Pro-Rehab Services, P.C.

**Physical Therapy and Rehabilitation Center**

## NEW PATIENT MEDICAL HISTORY INFORMATION

**Please answer the following questions about your medical history.**

**Patient Name** _____ **Date of Birth** _____

## COVID-19 Screening

### In the past 14 days:

Have you travelled internationally to countries with sustained community transmission? Yes ☐ No☐.

Contact with anyone who has confirmed or suspected COVID-19 ? Yes ☐ No☐.

Contact with anyone sick with cold of flu? Yes ☐ No☐.

Had Cold of flu or any respiratory symptoms? Yes ☐ No☐.

### In the past 7 days:

Contact with anyone who had a fever, nausea and vomiting, or diarrhea? Yes ☐ No☐.

### Do you presently have:

Fever? Yes ☐ No☐. C Cough or sore throat? Yes ☐ No☐. Shortness of breath? Yes ☐ No☐.

Chills or repeated shaking with chills? Yes ☐ No☐. Muscle ache? Yes ☐ No☐.

Loss of smell or taste? Yes ☐ No☐. Nausea and vomiting or diarrhea? Yes ☐ No☐.

1) What Problems are you being treated for today? _____
2) When did your problem/s begin? _____
3) How did your problem/s begin? _____
4) Have you had any surgeries related to this problem? Yes ☐ No☐.
5) If Yes, Type of surgery and Date _____
6) Have you received treatment of these symptoms? Yes ☐ No ☐
7) Have your received outpatient Physical Therapy for this condition? Yes ☐ No ☐
8) 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)**
9) If yes, Name of Agency _____ Phone No. _____

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10) Are you currently working? Yes ☐ No ☐

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

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

13) Are you currently taking any medications? Yes ☐ No ☐

If yes, please list medications _____

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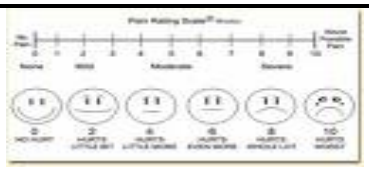

15) If you have pain, what is the current level of pain?

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

_____

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

X-ray ☐ MRI ☐ Bone Scan ☐ CT Scan ☐ Blood Tests ☐

17) Please **CHECK** the boxes next to any conditions that are applicable to you.

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

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

_____

_____

_____

_____

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

_____

19) What is your goal in therapy?

_____

_____

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

_____

Patient Signature Date