



Patient Medical History

Name: _____ Referring Physician: _____

Date of Injury: _____ Date of next Doctors visit for this injury: _____

Have you had surgery for this injury: ___ Yes ___ No Date of surgery: _____

Are you currently taking any prescription or non-prescription medications? : ___ Yes ___ No

Please list all medications you are currently taking, please include dosage:

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

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	_____	_____	Severe or frequent headaches	_____	_____
Shortness of breath/ Chest pain	_____	_____	Vision or hearing difficulties	_____	_____
Coronary artery disease or Angina	_____	_____	Numbness or tingling	_____	_____
Do you have a pacemaker?	_____	_____	Dizziness or fainting	_____	_____
High blood pressure	_____	_____	Bowel or bladder problems	_____	_____
Heart attack or Surgery	_____	_____	Weakness	_____	_____
Stroke/ TIA	_____	_____	Weight loss/ Energy loss	_____	_____
Congestive heart disease	_____	_____	Hernia	_____	_____
Blood clot/ Emboli	_____	_____	Varicose veins	_____	_____
Epilepsy/ Seizures	_____	_____	Allergies	_____	_____
Thyroid Disease or Goiter	_____	_____	Any pins or Metal implants	_____	_____
Anemia	_____	_____	Joint replacement surgery	_____	_____
Infectious diseases	_____	_____	Neck injury/ Surgery	_____	_____
Diabetes	_____	_____	Shoulder injury/ Surgery	_____	_____
Cancer or chemotherapy	_____	_____	Elbow/ Hand injury/ Surgery	_____	_____
Arthritis	_____	_____	Back injury/ Surgery	_____	_____
Osteoporosis	_____	_____	Knee injury/ Surgery	_____	_____
Gout	_____	_____	Leg/ Ankle/ Foot injury/ Surgery	_____	_____
Sleeping problems/ Difficulties	_____	_____	Are you pregnant?	_____	_____
Emotional/ Psychological problems	_____	_____	Do you use Tobacco?	_____	_____
			If yes how long have you used tobacco?	_____	_____
			How often do you use tobacco?	_____	_____

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

What are your rehabilitation expectations/ goals while in this program? _____

Patient/ Guardian Signature: _____ Date: _____