OUTPATIENT REHABILITATION
PATIENT INFORMATION AND BRIEF MEDICAL HISTORY

Federal and State Regulations require a medical history must be included in the patient's medical records in this office.

Date: _____ Birthdate: _____ OP Med Rec # _____

Patient Name: _____ Patient Phone # _____

Reason For Therapy Referral: _____

Date of Onset/Injury/Surgery _____ Physician: _____

MEDICAL HISTORY:

Do you have/or have you had any of the following:

Diabetes	Yes	No	Sensitivity to heat	Yes	No
High Blood Pressure	Yes	No	Sensitivity to cold (ice)	Yes	No
Circulatory Disorders	Yes	No	Dizziness	Yes	No
Heart Disease	Yes	No	Seizures	Yes	No
Heart Attack	Yes	No	Headaches	Yes	No
Stroke/TIA	Yes	No	Cancer	Yes	No
Pacemaker	Yes	No	Visual Problem	Yes	No
Metal Implants	Yes	No	Allergies	Yes	No
Kidney Problems	Yes	No	Previous Surgeries	Yes	No
Hernia	Yes	No	Back Injuries	Yes	No
Nervous Disorders	Yes	No	Other Injuries	Yes	No
Are you pregnant?	Yes	No	Other Illnesses	Yes	No
Breathing Difficulties	Yes	No	Difficulty Sleeping	Yes	No
Osteoporosis	Yes	No	Neurological Problems	Yes	No
Weight Loss	Yes	No	DVT/Pulmonary Embolism	Yes	No

If Yes on any of the above, please explain and give approximate dates: _____

MEDICATIONS:

Yes No Are you presently taking medications?

If Yes, please list what medications, dosage and for what condition:

Medication	Dosage	Condition

OTHER INFORMATION:

Yes No Have you had previous therapy for the present condition for which you are to receive treatment here?

Yes No Is this a work related injury or condition?

Yes No Has this injury been reported to your employer?