Patient Medical Information

Date _____

Patient Name _____

Date of Birth _____

Referring Physician _____

Family Physician _____

Your Chief Complaint: _____

Date of Injury: _____ If not an injury, date of onset of symptoms: _____

Date of 1st Physician visit for this injury: _____ Are you aware of what your diagnosis is? ☐ Yes ☐ No

What are your rehabilitation expectations or goals? _____

Occupation: _____ or ☐ Retired ☐ Student

Work Status: ☐ Full Time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Off work

Last date worked due to this injury: _____ Date returned to work after this injury: _____

Have you had surgery for this injury? ☐ Yes ☐ No Date returned to work after this surgery: _____

Approximate height and weight: _____ feet _____ inches / _____pounds

Please circle yes or no. Have you had any of the following Medical and / or Rehabilitation Services for **this** injury / episode?

X-Ray	Y	N	Myelogram	Y	N	General Practitioner	Y	N
MRI	Y	N	Physical Therapy	Y	N	Orthopedist	Y	N
CT-Scan	Y	N	Occupational Therapy	Y	N	Neurologist	Y	N
EMG / Nerve Conduction	Y	N	Massage Therapy	Y	N	Emergency Room Care	Y	N

What is your **current** pain level? (Circle) 0 = no pain; 10 = worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

What is your pain level at its **best**? (Circle) 0 = no pain; 10 = worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

What is your pain level at its **worst**? (Circle) 0 = no pain; 10 = worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

What activities make your pain worse? (Check all that apply)

☐ Exercise ☐ Bending forward ☐ Coughing/sneezing ☐ When still
☐ Sitting ☐ Bending backward ☐ Stairs ☐ On the move
☐ Standing ☐ Lying on your back ☐ Turning ☐ Other (specify):
☐ Walking ☐ Lying on stomach ☐ Lifting _____

What activities reduce your pain? (Check all that apply)

☐ Sitting ☐ Bending forward ☐ Lying on stomach ☐ Rest
☐ Standing ☐ Bending backward ☐ Medication ☐ Heat / ice pack
☐ Walking ☐ Lying on your back ☐ Exercise or PT ☐ Other (specify):
_____

Have you fallen in the past year?

☐ No ☐ Yes (how many falls?) _____

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Patient Medical History

Name: _____ Date _____

Please circle yes or no. Are you having or have had any of the following problems?

Constitutional			**Respiratory**			**Gastrointestinal**		
Good General Health	Y	N	Shortage of Breath	Y	N	Nausea / Vomiting	Y	N
Recent Weight Changes	Y	N	Excessive Coughing	Y	N	Abdominal Pain	Y	N
Fatigue	Y	N	Asthma	Y	N	Rectal Bleeding	Y	N
Night Sweats / Fevers	Y	N	Bronchitis	Y	N	Blood in Urine	Y	N
Cardiovascular			Emphysema	Y	N	Kidney Stones	Y	N
Angina / Chest Pain	Y	N	**Neurological**			**Other**		
Coronary Disease	Y	N	Frequent Headaches	Y	N	Changes in Hair / Nails	Y	N
Heart Surgery	Y	N	Seizures / Epilepsy	Y	N	Rashes / Itching	Y	N
Pacemaker	Y	N	Numbness / Tingling	Y	N	Breast Lump	Y	N
Musculoskeletal			Dizziness	Y	N	Breast Pain / Discharge	Y	N
Muscle Pain or Cramps	Y	N	Weakness	Y	N	Changes in Menstrual Cycle	Y	N
Stiffness / Swelling in the Joints	Y	N	Stroke / TIA	Y	N	Tuberculosis	Y	N
Joint Pain	Y	N	**Hematological / Lymphatic**			Cancer	Y	N
Osteoporosis	Y	N	Bruise Easily	Y	N	Chemotherapy / Radiation	Y	N
Endocrine			Slow to Heal	Y	N	HIV / AIDS	Y	N
Excessive Thirst / Urination	Y	N	Enlarged Glands	Y	N	Diabetes	Y	N
Thyroid Disease	Y	N	**Eyes**			Blood Clots	Y	N
Hormone Problems	Y	N	Wear Glasses / Contacts	Y	N	Depression	Y	N
Ear/Nose/Throat/Mouth			Blurred / Double Vision	Y	N	Insomnia	Y	N
Hearing Loss / Ringing in Ears	Y	N	Eye Disease or Injury	Y	N	Confusion	Y	N
Sinus Problems	Y	N	Glaucoma	Y	N	Memory Loss	Y	N
Nose Bleeds	Y	N	**Allergies**			Do you smoke?	Y	N
Sore Throat	Y	N	Food	Y	N	Do you use tobacco products?	Y	N
Voice Changes	Y	N	Medicine	Y	N	Are you pregnant?	Y	N

Surgical History

Surgery	Approximate Date

Medical Conditions (ie high blood pressure, diabetes, etc)

Medical Condition	Date of onset

Medication List (prescription and non-prescription)

Medication	Taken for

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