Center of Rehabilitative Excellence – Medical History

Name: ____ **Height:** ______ **Weight:** ______ **Birthdate:** _____/_____/_____ **Age:** _____

Emergency Contact: Name:______________________________________ **Phone #:** ______________________________________

PATIENT MEDICAL HISTORY: (please check all that apply)

____ Heart Disease	____ Diabetes	____ Hepatitis	____ Hearing Impaired	____ Epilepsy
____ Cancer	____ Tuberculosis	____ High Blood Pressure	____ Latex Allergy	____ Fibromyalgia
____ HIV/AIDS	____ Arthritis	____ Visually Impaired	____ Pregnant	____ Scoliosis
____ Stroke	____ Asthma		____ Pacemaker	____ Low Blood Sugar
____ Osteoporosis	____ Anemia			

____ **Other** ____

Why have you been referred for therapy/ main complaint:
____?

Have you had surgery for your condition? ☐**Yes** ☐**No If yes, please give approximate date:** ____________________

Have you had injections for your condition? ☐**Yes** ☐**No If yes, please give approximate date:** ____________________

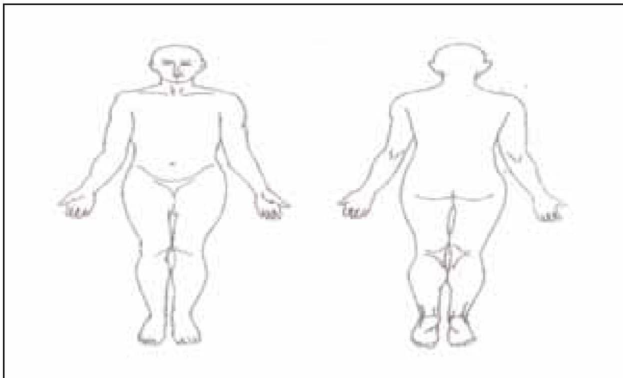
Please list any diagnostic tests (x-rays, MRI) you have had for this condition: ______________________________

What are your current symptoms? ____

When did the injury or symptoms occur? 1st episode: __________ **2nd episode:** __________ **3rd episode:** __________

How did the injury or problem occur? ____

What makes your pain / problem better? __________________________ **Worse?** ___________________________



Please draw the following symbols on the picture below to describe the type of pain you are experiencing and where you are experiencing the pain.

XX = STABBING

OO = NUMBNESS

// = SHOOTING

:: = ACHING

Please rate your pain 0-10: 0=no pain 10=pain so severe you need to go to the ER **Current pain level:** ______

What do you hope to accomplish with therapy? ____

What type of non-work activities are you involved in? ____

Occupation: ________________________ **Work Duties:** ____

When are you scheduled to see your doctor again? ______________

***MEDICARE PATIENTS*: Are you receiving any home health services from a nurse, nurse assistant, speech therapist, occupational therapist, physical therapist, or any other healthcare provider at this time?** ☐**YES** ☐**NO**

____ ____________________

Patient Signature **Date**

*****Please list all medications you are currently taking on the back of this page.**

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List medications you are taking. Include the name and the phone number of the physician prescribing the medication.

Medication	Physician	Phone Number
____________________	____________________	______________
____________________	____________________	______________
____________________	____________________	______________
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