PATIENT MEDICAL HISTORY

Name: _____ Referring Physician: _____
Family Physician: _____ Date of First Doctor visit for this injury: _____
Last Date worked Due to this injury: _____
Date returned to work after this injury: _____
Is an Attorney Involved in this case? YES NO
Have you had Surgery for this injury? YES NO Number of Surgeries 1 2 3 4
Type of Surgery_____
Took Place in: Hospital Surgery Center
Are You Currently Taking Any Prescription or Non-Prescription Medications YES NO
Anti-inflammatories_____ Muscle Relaxant_____ Pain Medication_____
List Medications:

_____

Are you Allergic to any Medications? YES NO List Medications: _____

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

Chiropractor	Yes	No	CT Scan	Yes	No
EMG/NCV			General Practitioner		
Massage Therapy			MRI		
Myelogram			Neurologist		
Occupational Therapy			Orthopedist		
Physical Therapy			Podiatrist		
Emergency Room Care			X Rays		
Other					

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

Asthma, Bronchitis, Emphysema	Yes	No	Severe or frequent Headaches	Yes	No
Shortness of breath/Chest Pain			Vision Hearing Difficulties		
Coronary Heart Disease /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		
Infectious Diseases			Neck Injury/Surgery		
Diabetes			Shoulder Injury/Surgery		
Cancer/Chemotherapy/Radiation			Elbow/Hand/Surgery		
Arthritis			Back Injury/Surgery		
Osteoporosis			Knee Injury/Surgery		
Gout			Leg/Ankle/Foot/Surgery		
Sleeping Problems/Difficulties			Are You Pregnant		
Emotional/Psychological Problem			Do you use tobacco		

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

Are you aware of your diagnosis? YES NO Based on your awareness. What are your rehabilitation expectations/goals while in this program?

_____

Would you like to speak to a social worker about any aspects of your rehabilitation? YES NO

Patient/Guardian Signature_____ Date_____