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A Medical Corporation

Physical Medicine & Rehabilitation
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Patient Name: ____ Date of Birth: __________________

Address: ____

City: ____ State: ________________ Zip: __________________

Phone: Home ________________________ Cell ________________________ Work ______________________

Email: ____ Age: ________ Sex: ☐M ☐F

Marital Status: ☐Never Married ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse/Significant Other: ______________________________________ Phone: ________________________

Education (circle highest level attended):
Grade School 7 8 9 10 11 12 College 1 2 3 4

Graduate School ____

Occupation: ______________________________________ Number of hours working/avg per week: ___________

Referred here by (check one): ☐Self ☐Family ☐Friend ☐Doctor ☐Other Health Professional

Name of who referred you: ____

Family/Internist/Primary Care Physician: ____

In Case of Emergency: Name: ___________________________________ Relationship: ____________________

Phone: Home ________________________ Cell ________________________ Work _______________________

Person Financially Responsible: (Fill out only if different from patient)

Name: ______________________________________ Relationship: ____________________________________

Phone: Home ________________________ Cell ________________________ Work _______________________

Address: ____

City: ____ State: ________________ Zip: ___________________

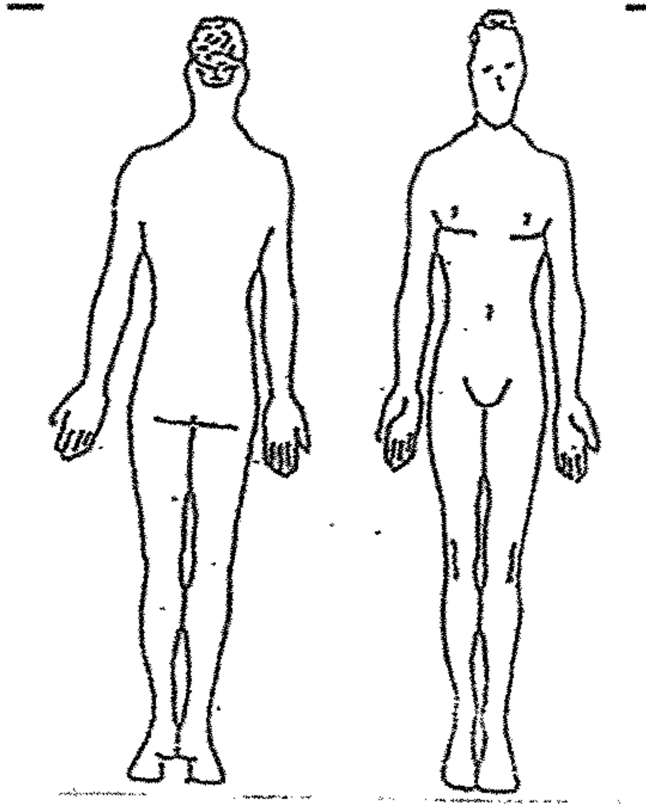
Medical History Form

Patient Name: ____ Date: __________________

Pain Rating: Please circle the degree of pain you are <u>currently</u> experiencing.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Burning oil on skin

Mark the areas where you feel pain/numbness/or tingling on your body.
Please use the following key: **#** numbness **X** pain **O** tingling



Height: __________

Weight: __________

When did your pain/symptoms begin? (approximate) ____

Are you getting: ☐Worse ☐Better ☐Stable

Please describe all <u>present</u> symptoms: ____

____

____

____

Is your pain a result from an injury? ☐Yes ☐No ☐Unsure Date of injury: ________________

Please give a brief history of how your symptoms began: ____

____

____

What position(s) and/or medication(s) relieves your symptoms? ___________________________________

____

What worsens your symptoms? ____

____

Have you had diagnostic tests such as an xray or MRI, etc related to your problem?

Test/study	Date:	Result:
__________	__________	____
__________	__________	____
__________	__________	____
__________	__________	____

Previous treatment(s) for this current medical issue? Please check all that apply (medications will be listed later)

☐Physical therapy ☐Home Exercises ☐Pilates
☐Acupuncture ☐Epidurals ☐Chiropractic
☐Bracing ☐Occupational Therapy
☐Injections: ☐Cortisone ☐Toradol ☐Hyaluronate ☐PRP ☐Stem Cell ☐Amnio

Have you had any surgical treatments related to the injured area?

Operation	Date:	Result:
__________	__________	____
__________	__________	____
__________	__________	____
__________	__________	____

Have you had any other serious injuries or fractures? ☐No ☐Yes

If yes, please describe: ____

____

Do you have any allergies to medication? ☐No ☐Yes

Which medication(s)? ____

____

Type of reaction(s): ____

____

Current Medications (list any medications you are currently taking including supplements, vitamins, etc)

Name of Drug	**Dose** (include strength and number of pills per day)	**How long you have taken this medication**	**Please check: Helpful?** Very	Somewhat	Not at all
1			☐	☐	☐
2			☐	☐	☐
3			☐	☐	☐
4			☐	☐	☐
5			☐	☐	☐
6			☐	☐	☐
7			☐	☐	☐
8			☐	☐	☐
9			☐	☐	☐
10			☐	☐	☐

Past Medications (list any medications you have tried, *how long* you were taking the medication, the *results* of the medication, and any *reactions* you may have had):

____

____

____

____

Review of Systems: Have you recently had any of the following? (check all that apply)

☐Fatigue
☐Fainting
☐Depression
☐Nervousness
☐Stress
☐Shortness of breath
☐Headaches
☐Numbness
☐Heartburn
☐Itching
☐Facial pain
☐Bowel problems
☐Ulcers
☐Nausea
☐Loss of appetite
☐Vomiting
☐Muscle Spasms
☐Joint pain/swelling
☐Loss of concentration
☐Memory loss
☐Difficulty sleeping
☐Difficulty hearing
☐Difficulty urinating
☐Muscle weakness/tenderness

If you are female, are you pregnant? ☐No ☐Yes

Past Medical History: Do you have a history of any of the following medical issues? (check all that apply)

☐Cancer	☐Heart Disease	☐Arthritis	☐Psychological
☐Diabetes	☐Stroke	☐Liver or Kidney	☐Eye/Ear/Nose
☐Respiratory	☐Asthma	☐Anemia	☐High Blood Pressure
☐Gastrointestinal	☐Autoimmune Disease		

Other significant illness (please list): ____

____

Social History

Do you smoke? ☐No ☐Yes – If yes, how much per day? ________ ☐Former – How long ago? _______

Do you drink alcohol? ☐No ☐Yes – If yes, how often/number of drinks per week? _________________

Do you use any recreational drugs? ☐No ☐Yes

If yes, please list: ____

Do you have a history of drug abuse? ☐No ☐Yes

If yes, please explain: ____

Do you exercise regularly? ☐No ☐Yes

Type: ____

Amount per week: ____

How many hours of sleep do you get at night? ____

Do you get enough sleep at night? ☐No ☐Yes

Do you wake up feeling rested? ☐No ☐Yes

Family History

Do you know of any blood relative/family members who has or had the following? (check and give relationship)

☐Spinal issues ____

☐Arthritis ____

☐Cancer ____

☐Heart disease ____

☐High blood pressure ____

☐Diabetes ____

☐Respiratory ____

☐Stroke ____

☐Alcoholism ____

☐Drug abuse ____

Activities of Daily Living

Do you have stairs to climb? ☐No ☐Yes If yes, how many? ______________________________________

How many people in household? ____________________

Who does most of the housework? __________________

Do you have anyone to help you at home? ☐No ☐Yes

On the scale below, circle a number which best describes your situation:

Most of the time, I function…

1	2	3	4	5
Very poorly	Poorly	OK	Well	Very well

Due to your health problems, do you have difficulty with:	Usually	Sometimes	No
Using your hands to grasp small objects (buttons, toothbrush, pencil, etc)	☐	☐	☐
Walking – how far/long can you walk? __________________	☐	☐	☐
Climbing stairs	☐	☐	☐
Descending stairs	☐	☐	☐
Sitting down	☐	☐	☐
Getting up from a chair	☐	☐	☐
Reaching behind your back	☐	☐	☐
Reaching upward	☐	☐	☐
Dressing yourself	☐	☐	☐
Going to sleep	☐	☐	☐
Staying asleep due to pain	☐	☐	☐
Bathing	☐	☐	☐
Eating	☐	☐	☐
Cooking	☐	☐	☐
Working	☐	☐	☐
Morning stiffness	☐	☐	☐
Do you use a cane, crutches, walker, wheelchair?	☐	☐	☐

What is the hardest thing for you to do?

____

____