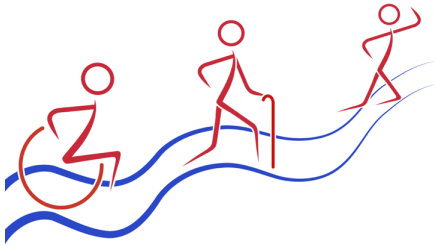
Grand River Rehabilitation

Serving adults & children with pain & disabilities



New Patient History Form (Adult)

Name _____ DOB _____ Sex _____
Reason for visit _____

_____

Physicians
Primary Care (PCP)_____ Orthopaedist _____
Neurologist _____ Physiatrist_____
Pulmonologist _____ Urologist _____
Eye Dr _____ ENT _____
Neurosurgeon _____ Dentist _____
Orthotist/Prosthetist _____ Other Physicians _____

Allergies (food, medication, latex) _____

_____

Medication	Dose	Frequency	Medication	Dose	Frequency

Please list any previous medications you have already tried for this same concern: _____

_____

Past Medical History
Immunizations up to date? ☐ Yes ☐ No Flu vaccine? ☐ Yes ☐ No
Please explain missed immunizations _____

Any chronic diseases or conditions (i.e. cerebral palsy, hydrocephalus, spina bifida, seizures, asthma, diabetes, heart disorder, etc.)? _____

_____

_____

_____

Has the patient ever had a concussion, traumatic brain injury, spinal cord injury, meningitis, encephalitis, hearing or vision loss, or other conditions impacting functioning? _____

_____

_____

Please list all surgeries, with approximate dates _____

_____

_____

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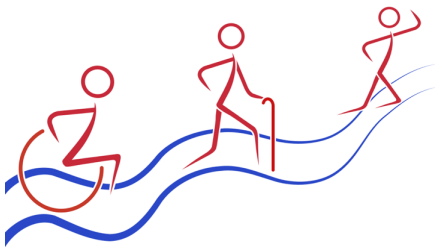

Any other medical problems?

_____

_____

Frequency of therapies

Speech therapy _____

Physical therapy _____

Occupational therapy _____

Other _____

Assistive devices used (splints/braces/cane/walker/wheelchair/etc) _____

Best means of mobility: ☐ Orthotics (braces) ☐ Walk with assistance ☐ Crutches ☐ Walker ☐ Wheelchair (manual/powered) ☐ Other _____

Best means of communication _____

Please bring braces, crutches, walker, wheelchair, communication devices, etc. to every appointment.

Independence with self-care (*I: Independent, P: Partially independent, U: Unable*)

Feed self with fingers	I	P	U	Drink from cup	I	P	U	Toilet self	I	P	U
Feed self with utensils	I	P	U	Wash face/hands	I	P	U				
Dress self	I	P	U	Bathe self	I	P	U				

Family (*not* personal) History

	No	Yes (specify diagnosis & relative)
Sudden death of young person		
Tuberculosis (TB)		
HIV		
Sickle cell		
Bleeding problems		
Seizures		
Anxiety/depression		
Migraine/cluster		
Chronic pain disorder		

	No	Yes (specify diagnosis & relative)
Learning problems (ADHD, dyslexia, etc.)		
Muscle disorder		
Fibromyalgia		
Neurologic disorder		
Spina bifida		
Cerebral palsy		
Genetic disorder		
Other		

Person filling out form:

_____ _____

Signature Relationship to patient

_____ _____

Name Date/time