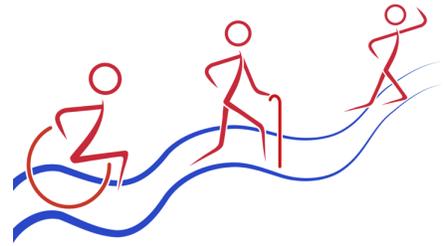


# Grand River Rehabilitation

*Serving adults & children with  
pain & disabilities*



## New Patient History Form (Adult)

Name \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_  
Reason for visit \_\_\_\_\_

### Physicians

Primary Care (PCP) \_\_\_\_\_ Orthopaedist \_\_\_\_\_  
Neurologist \_\_\_\_\_ Psychiatrist \_\_\_\_\_  
Pulmonologist \_\_\_\_\_ Urologist \_\_\_\_\_  
Eye Dr \_\_\_\_\_ ENT \_\_\_\_\_  
Neurosurgeon \_\_\_\_\_ Dentist \_\_\_\_\_  
Orthotist/Prosthetist \_\_\_\_\_ Other Physicians \_\_\_\_\_  
Preferred Pharmacy \_\_\_\_\_  
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 \_\_\_\_\_

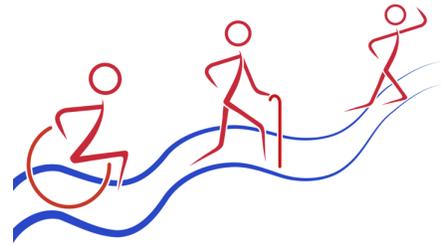
Any chronic diseases or conditions (i.e. cerebral palsy, hydrocephalus, spina bifida, seizures, asthma, diabetes, heart disorder, etc.)? \_\_\_\_\_

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 \_\_\_\_\_

# Grand River Rehabilitation

**Serving adults & children with pain & disabilities**



Any other medical problems?

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## 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/powerd)  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

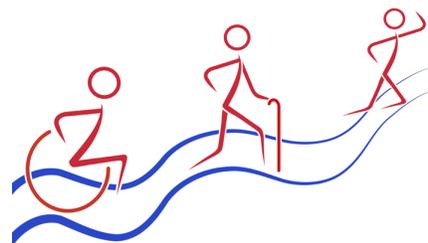
\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date/time

# Grand River Rehabilitation

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Review of Systems (check any that apply to you **currently or within the last 2 weeks**):

## Constitutional

Fever	
Night sweats	
Weight loss	
Weight gain	
Chills	
Exercise intolerance	
Fatigue	

## Eyes

Dry eyes	
Vision changes	
Irritation/ Redness	
Double vision	
Eye injury	

## Respiratory

Cough	
Wheezing	
Shortness of breath	
Coughing up blood	
Snoring	

## Ear, Nose, Throat

Difficulty hearing	
Ear pain	
Nosebleed	
Sinus problems	
Sore throat	
Bleeding gums	
Dry mouth	
Mouth ulcers	
Teeth problems	
Ear ringing	

## Cardiovascular

Chest pain	
Arm pain	
Palpitations	
Heart murmur	
Ankle swelling	

## Gastrointestinal

Abdominal pain	
Nausea	
Vomiting	
Changes in appetite	
Diarrhea	
Acid reflux	
Constipation	

## Muskuloskeletal

Muscle aches	
Muscle weakness	
Joint pain	
Back pain	
Neck pain	
Difficulty walking	
Muscle cramps	
Osteoporosis	
Fracture(s)	

## Neurologic

Loss of consciousness	
Stroke	
Weakness	
Numbness	
Seizures	
Dizziness	
Headaches	
Tremor(s)	
Abnormal gait	
Paralysis	

## Miscellaneous

Depression	
Sleep disturbances	
Behavioral problems	
Alcohol abuse	
Anxiety	
Hallucinations	
Suicidal thoughts	
Mood swings	
Memory loss	
Irritability	