Marina

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**PATIENT INTAKE HISTORY FORM**

Please (X) if you have ever been treated or you are now being treated for any of the following conditions.

**YES NO ANY EXPLANATIONS**

**CONDITION:**

Lower Back Problems:

Neck Problems:

Shoulder, Arm, Hand Problems:

Broken Bones:

Metal Implants (Screws, Plates, etc.):

Leg Problems:

Heart Troubles or Surgeries:

Pacemaker:

Circulation Problems or Blood Clots:

Diabetes:

Tumors and/or Cancer:

Tuberculosis:

Headaches:

Digestive Problems, Vomiting, Nausea:

Seizures:

Dizziness, Ringing in the Ear:

Are You Pregnant Now?

Number of Past Pregnancies:

Allergies (please specify):

Major Surgeries:

Major Accidents:

Any Other Major Conditions:

If you answered yes to any of the above questions, please explain, and list all the medications that you are currently taking, with information you feel that this center should know.

Patient Name: (Print) Patient Name: (Signature)

Witness: Date: