Next Step Rehabilitation

PATIENT REGISTRATION and MEDICAL HISTORY

DATE: ___ / ___ / ___

Patient Name:	S.S. #:	Date of Birth:	Age:
Address	City State Zip	Home Phone:	
Email address:		Cell Phone:	
Employer:	Occupation:	Work Phone:	
Emergency Contact Name:	Relationship to Patient:	Phone:	
Referring Physician:	Primary Care Physician (if different):		
Have you recently or are you currently being treated by Home Health therapist, nurse, etc..? Yes No			
Date of Injury (if applicable):	Date of Surgery (if applicable):		

MEDICAL HISTORY

Please check if you have ever had any of the following.

- ❑ Asthma, Bronchitis, Emphysema
- ❑ Shortness of Breath / Chest Pain
- ❑ Heart or Coronary Artery Problems
- ❑ High Blood Pressure
- ❑ Pacemaker
- ❑ Diabetes / High Blood Sugar
- ❑ Stroke / TIA / Blood Clots
- ❑ Seizure / Epilepsy
- ❑ Infectious Diseases
- ❑ Cancer - Chemo / Radiation Therapy
- ❑ Hernia
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Joint Replacement / Metal Implants
- ❑ Neck / Back Injury / Surgery
- ❑ Shoulder Injury / Surgery
- ❑ Elbow / Hand Injury / Surgery
- ❑ Hip Injury / Surgery
- ❑ Knee / Ankle Injury / Surgery
- ❑ Severe or Frequent Headaches
- ❑ Bowel or Bladder Problems
- ❑ Numbness or Tingling
- ❑ Weakness / Weight or Energy Loss
- ❑ Dizziness / Vertigo / Fainting
- ❑ Visual / Hearing Problems
- ❑ Emotional / Psychological Problems
- ❑ Are you pregnant?
- ❑ Do you smoke?
- ❑ Allergies
- ❑ Other: _____

_____

_____

_____

Your Chief Complaint: _____

_____

Any Past Treatment (if so, what)? _____

_____

Any Previous Tests & Results? _____

_____

Any Previous Surgeries? _____

_____

Current Medications: _____

_____

What are your goals for therapy? _____

_____