BONNEY LAKE
Physical Therapy & Hand Rehab, PLLC

Brief Medical History

Please Print Clearly

Patient Name:_____DOB:_____ Injury/onset date:_____Surgery date:_____

Street Address:_____City, State, Zip:_____

Contact phone:_____(cell/home) Other Number / parent:_____ (cell/home)

E-mail address:_____Sex: F / M Marital Status: M__ S__ W__ D__ O__

Emergency Contact/Guardian/Power of Attorney _____Phone_____Relation:_____

List all Doctors/Medical Providers: _____

Accident related? y / n Auto: y / n On someone elses Property: y / n Attorney/phone: _____

Hand Dominance: Right / Left **Height:_____Weight:_____ BMI:_____ MEDICARE REQUIRED**

How many falls in the past 12 months?_____ Falls with Injuries?_____ MEDICARE REQUIRED

Medication/Vitamin/Supplement List Attached____ Must include name, dosage, freq & type MEDICARE REQUIRED

Current Medications: _____

_____

Allergies/Sensitivity: Medications/Lotions/Fragrances/Latex/Heat or ice _____

Pain scale "0-10": (0 = no pain - 10 = Excruciating): Now:_____ Rest:_____Activity:____ MEDICARE REQUIRED

List and rate 3 difficult activities due to your injury/condition? 0= No difficulty 10=Unable to perform activity

1 _____ **Impairment Rating (0-10)** _____

2 _____ **Impairment Rating (0-10)** _____ **MEDICARE REQUIRED**

3 _____ **Impairment Rating (0-10)** _____ **Score**_____

Employment: Full Time / Part Time / Homemaker / Retired / Disabled / Student / Unemployed Employer: _____

If employed; Job Title & Duties: _____

Goals for Therapy: _____

Please indicate any conditions you have now or in the past:

Diabetes	Yes/No	Controlled	Yes / No	Asthma	Yes/No	Controlled	Yes / No
High Blood Pressure	Yes/No	Controlled	Yes / No	Lung / Pulmonary Disorders			Yes / No
Heart Disease / Attack			Yes / No	Tobacco use: Smoke/Chew/Electronic?			Yes / No
Pacemaker			Yes / No	Pregnancy:	Current		Yes / No
Circulatory Disorders: Cardiac/Extremity			Yes / No	Cancer: Type	_____		Yes / No
TMJ Disorders			Yes / No	Other Illness: list	_____		Yes / No
Headaches/Migraine			Yes / No	Previous Accidents: Auto/Work			Yes / No
Nervous Disorders			Yes / No	Surgeries (non-orthopedic)	list below		Yes / No
CVA / Stroke			Yes / No	Hernia: Inguinal / Umbilical / Hiatal		Any surge	Yes / No
Head Injury/Concussion/TBI/CHI			Yes / No	Skin conditions / wounds / rashes			Yes / No
Forgetfulness			Yes / No	Orthopedic injuries/concerns (Spine/extremity)			Yes / No
Depression/Emotional/Suicidal thoughts			Yes / No	Orthopedic Implants or Artificial Joints			Yes / No
Dizziness/Vertigo/Seizures			Yes / No	Orthopedic Surgeries:	list below		Yes / No
Eye problems, Blurred vision, Cataracts			Yes / No	Arthritis: list affected joints			Yes / No
Kidney Disorders			Yes / No				

Please list / explain any above: _____

_____

_____

_____

Previous treatment(s) for condition: Y / N (If yes, please explain) _____

The undersigned acknowledges and agrees that the above information is true and correct.

Signature _____ Date _____