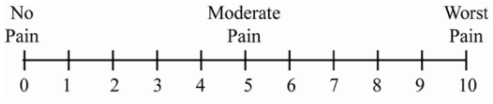
Progressive Step Rehabilitation Past Medical History Intake Form

Patient Name:_____ Sex __ M __F Today's Date:_____

Date of Birth:_____ Date of last physical exam_____ Occupation_____

Leisure Activities_____

What part of the body are you being seen for today?_____



0= No Pain, 10= Emergency Room Pain - Please **CIRCLE** level of pain

Current Problem is the result of a __Car Accident __Work Accident __Other/Specify_____ Date of Injury:_____

Have **you or anyone** in your family been diagnosed with any of the following? Please ☑check if any apply.

	SELF	MOTHER	FATHER	MATERNAL GRANDPARENT	PATERNAL GRANDPARENT	BROTHER/SISTER
High Blood Pressure/Hypertension						
Heart Attack/Heart Surgery						
Heart Disease, **Do you have a Pace Maker?**						
Diabetes						
Stroke						
Cancer Type/Location						
Osteoporosis						
Kidney Disease						
Circulation Problems						
Thyroid Problems						
Immune Disorders/Type						
Blood Clot						
Inflammatory Arthritis (Rheumatiod, Anklosing)						
Chemical Dependency (Alcoholism, Drug)						
Do you have Metal Implants?						
Communicable Disease (HIV, Hepatitis)						

Please ☑check any of the following that are **NEW**, **UNUSUAL** or **NON-TYPICAL** for you

	weight loss/gain		problems sleeping		constipation/diarrhea		eye redness
	nausea/vomiting		sexual difficulties		blood in stools		difficulty swallowing
	dizziness/lightheaded		night sweats		post menopause		stress at home or work
	fatigue/weakness		hearing problems		problems urinating		arm/leg swelling
	seizures		Joint/muscle swelling		urinary incontinence		excessive bleeding
	fever/chills/sweats		easy bruising		blood in urine		double vision/loss of vision
	numbness or tingling		difficulty breathing		skin rash		heart racing/chest
	tremors		regular cough		Heartburn/indigestion		pregnant or think you may be

Patient/Guarantor Signature_____ Print Name_____ Date_____

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Social History

Smoke Currently? ___ NO ___ YES ___packs per day for _____ years _____ Never Smoked
Quit Smoking? ___ This year ____ >1year ____>5 years ____>10 years
Previously smoked _____ packs per day for _____ years

Drink alcohol? ___ NO ___YES How many drinks _____ ___Daily ___1-2/week ___1-2/month ___1-2/year

History of substance abuse? ___NO ___YES What?_____

Exercise? ___Daily ___Weekly ___Monthly ___Rarely ___Never

What type of exercise?_____

Surgeries/Hospitalizations	Year	Complications

Previous Fractures or Sprains	Year

Allergies

Medications	Dosage	Medications	Dosage

Patient/Guarantor Signature_____ Print Name_____ Date_____