Striving for Excellence in Rehabilitation Care

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NEW PATIENT HISTORY FORM

1. Patient Name: ________________________ Date: ___/___/___ Diagnosis: ________________________________

2. Referring MD: _________________ Date of first MD visit for this injury: ___/___/___ Next MD appointment? ___/___/___
   Gender: M F Birth Date: ___/___/___ Hand dominance: R L Occupation: _______________________

3. Have you had any diagnostic tests performed? YES NO If so, indicate which tests & approximate dates:
   X-ray:_________ MRI: _________ CT scan: _________ Bone Density: _________ Myelogram: _________
   EMG: _________ NCV: _________ Other: ____

4. Have you missed any work due to this injury? YES NO
5. If so, last date worked was? _________ Date returned to work? __________ Worked part-time for a period of: _________

6. Have you had surgery for this injury? YES NO If so, how many surgeries? 1 2 3 4
   Procedure(s) performed: ____
   Most recent procedure: ________________________ Surgeon: __________________ Date of last surgery: _________

7. Are you currently taking any prescription or non-prescription medications (for this condition or anything else)? YES NO
8. Please list in the appropriate categories:
   Anti-inflammatories:___________________________ High Blood Pressure Meds: ___________________________
   Muscle Relaxers: ___________________________ Bone Density Drugs:_____________________________
   Pain Medication: ___________________________ Beta Blockers:_____________________________
   Antibiotics: ___________________________ Other: _____________________________

9. Have you sought care from any of the following medical providers for this injury/episode?

1.	YES	NO		YES	NO		YES	NO
Emergency Room Care	____	____	General Practitioner	____	____	Acupuncturist	____	____
Orthopaedist	____	____	Physical Therapist	____	____	Massage Therapist	____	____
Neurologist	____	____	Chiropractor	____	____	Other ________________________		
Podiatrist	____	____	Occupational Therapist	____	____			

10. Do you normally participate in any fitness activities or recreational sports? YES NO
11. List: ____

12. How have you modified your activites do to your injury/episode?
    ____

13. Did your referring MD give you any instructions (i.e.: for exercise, weight-bearing, weaning from crutches, use of a brace)?
    YES NO Please elaborate: ____
    ____

14. **Orthopaedic History:**
    Please indicate **any musculoskeletal or neurological problems/injuries/surgeries you have experienced in the past**.
    Include even those that occurred long ago or seem completely unrelated.
    DO YOU EXPERIENCE RESIDUAL SYMPTOMS?________________

15. CONDITION or INJURY / SURGERY — APPROX. DATES — YES NO

CONDITION or INJURY / SURGERY	APPROX. DATES	YES	NO
________________________________	_______________	____	____
________________________________	_______________	____	____
________________________________	_______________	____	____
________________________________	_______________	____	____

General Medical History: Do you now have or have you ever had ANY of the following:

	YES	NO	Use this space to explain
Allergies	____	____	____
Anemia	____	____	____
Arthritis:			

Osteoarthritis ____ ____ ____________________
Rheumatoid arthritis ____ ____ ____________________
Asthma ____ ____ ____________________
Blood Clot/Embolus ____ ____ ____________________
Blood Clotting Difficulty ____ ____ ____________________
Bowel or Bladder problems ____ ____ ____________________
Cancer ____ ____ ____________________
Chemotherapy or Radiation ____ ____ ____________________
Chest Pain ____ ____ ____________________
Chronic Fatigue Syndrome ____ ____ ____________________
Coronary Heart Disease or Angina ____ ____ ____________________
Coronary Bypass Sx/Angioplasty ____ ____ ____________________
Diabetes ____ ____ ____________________
Dizziness or Fainting ____ ____ ____________________
Emphysema/Pulmonary Problems ____ ____ ____________________
Emotional/psychological problems ____ ____ ____________________
Epilepsy/seizures ____ ____ ____________________
Fibromyalgia ____ ____ ____________________
Gout ____ ____ ____________________
Headaches (severe or frequent) ____ ____ ____________________
Hearing Difficulties ____ ____ ____________________
Heart Attack ____ ____ ____________________
Hernia ____ ____ ____________________
High Blood Pressure ____ ____ ____________________
HIV/AIDS ____ ____ ____________________
Infectious Diseases ____ ____ ____________________
Joint Replacement: (circle) Hip Knee Shoulder Other ____________________
Lupus ____ ____ ____________________
Lyme Disease ____ ____ ____________________
Metal Implants or Pins ____ ____ ____________________
Muscle Weakness ____ ____ ____________________
Neurological Problems ____ ____ ____________________
Numbness or Tingling ____ ____ ____________________
Osteoporosis ____ ____ ____________________
A Pacemaker ____ ____ ____________________
RSD ____ ____ ____________________
Sarcoidosis ____ ____ ____________________
Shingles ____ ____ ____________________
Shortness of Breath ____ ____ ____________________
Sleeping Problems ____ ____ ____________________
Stroke or TIA ____ ____ ____________________
Thyroid trouble or goiter ____ ____ ____________________
Vascular Problems ____ ____ ____________________
Vision Difficulties ____ ____ ____________________
Weight/energy loss ____ ____ ____________________

Other: ____________________

Are you pregnant? YES NO

Do you smoke? YES NO

Do you drink? YES NO

What are your goals while in this program? ____________________-
____

Patient/Guardian Signature: ____________________ **Print Name**: ____________________ **Date**:___/___/___