GENUINE
rehab wellness

BACKGROUND INFORMATION / MEDICAL HISTORY

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you don't understand a question, leave the area blank and your therapist will assist you. Thank you!

Patient's Name: **Date of Birth:** **Age:** **Gender: M F**

Are you currently: (please check one)

___ Working at your usual job without restrictions
___ Working at your usual job with restrictions
___ Retired / Unemployed / Homemaker
___ Unable to work because of your condition (Off work since _____)
___ Student

Primary Care Physician Name: _____

What is your primary reason for today's appointment? _____

Please briefly describe your symptoms: _____

_____

Onset Date: _____ **Duration:** _____

Have you ever been seen for this problem? Yes No

If **Yes**, by which profession (i.e. doctor, physical therapist, chiropractor, etc.) _____

Past Medical History - Have you EVER been diagnosed with any of the following conditions? (Please check all that apply)

___ Heart disease
___ Heart attack
___ Irregular heart rhythm
___ Chest pain / Angina
___ Asthma
___ Shortness of breath
___ Emphysema / Bronchitis
___ Diabetes (Type I or Type II)
___ Hypertension (High blood pressure)
___ Low blood pressure
___ Osteoporosis
___ Arthritis
___ Rheumatoid arthritis
___ Cancer
___ Stroke
___ Multiple sclerosis
___ Epilepsy
___ Thyroid problems
___ Hepatitis
___ Tuberculosis
___ Bladder / Urinary tract infection
___ Anemia
___ Blood clots
___ Circulation problems
___ Current pregnancy: # of months_____
___ Past pregnancy
___ Pelvic Inflammatory Disease
___Depression / Anxiety
___ Chemical dependency
___ Other: _____

Past Surgical History (Please include type and date):

_____

_____

List all known allergies including latex, rubber, and tape:

_____

How many cups of caffeinated coffee or caffeine containing beverages do you consume per day? _____

Are you a Smoker? YES NO **If YES, how many packs per day?** _____

How many alcoholic drinks per week do you consume? _____

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

___ Aspirin ___ Laxatives ___ Naproxin / Aleve
___ Tylenol ___ Antacid ___ Other: _____
___ Advil / Motrin / Ibuprofen ___ Vitamins / mineral supplements

Please list all know prescription medications you are currently taking, to include the frequency, dosage and method of delivery (i.e. oral, injection, etc.), or you may attach list:

Medication	Dosage	How Often	Method of Delivery (i.e., injection, etc.)

During the past month, have you been feeling down, depressed, or hopeless? YES _____ NO _____

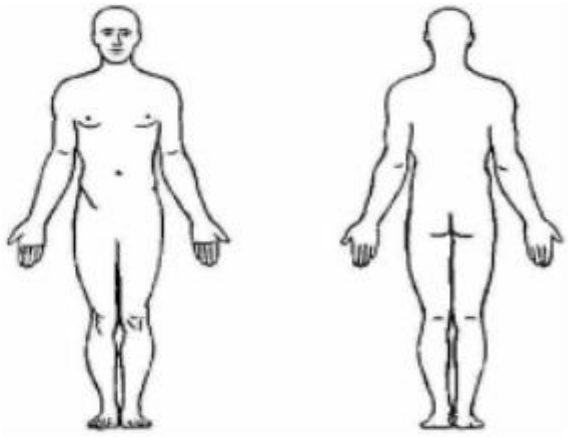
During the past month, have you had little interest or pleasure in doing things? YES _____ NO _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ Shooting/Sharp pain ||| Numbness

○ Dull/aching pain = Tingling



Current Level of Pain:

No pain 1 2 3 4 5 6 7 8 9 10 Worst imaginable pain

BEST for the last 48 hours:

No pain 1 2 3 4 5 6 7 8 9 10 Worst imaginable pain

WORST for the last 48 hours:

No pain 1 2 3 4 5 6 7 8 9 10 Worst imaginable pain

WHAT IS YOUR PERSONAL GOAL FOR THERAPY? _____

Signature: _____Date: _____

Form reviewed with patient? ____YES ____ NO Therapist initials _____