

UNIVERSITY REHABILITATION/JAMES CORWIN
 MEDICAL HISTORY
 PLEASE PRINT ALL INFORMATION

Name: _____ Occupation: _____
 Are you currently working? _____

PRESENT ILLNESS OR INJURY:

What is your current problem? _____

How did the present injury occur? _____

Date of injury? (Please give approx. For example "6 months ago") _____

Did you undergo surgery? Yes _____ NO _____ If Yes, when? _____

Have you had any testing? NO _____ Yes _____ /CT Scan ___ MRI ___ XRAY ___ EMG _____

Have you had any previous therapy for this problem? NO _____ Yes _____ if yes, when? _____

Have you had or are you having home health? NO _____ Yes _____ if yes, when? _____

If you have any pain or discomfort please describe:

*Location of pain _____ Intensity of pain (1-10 scale, 1=lowest) _____

*Constant or intermittent: _____ What aggravates it? _____

*How does rest affect it? _____

*How does medication affect it? _____

What can't you do with this condition? _____

What other symptoms do you Have? (Example: weakness, numbness, less movement, etc.) _____

MEDICAL HISTORY, PLEASE CIRCLE YES OR NO

Condition	Yes	No	Condition	Yes	No
Acute Infections	Yes	No	Infectious Diseases	Yes	No
Alcoholism / Drug Problems	Yes	No	Joint Problems	Yes	No
Allergies	Yes	No	Kidney Disease	Yes	No
Arthritis Problems	Yes	No	Metal Implant	Yes	No
Balance/Dizziness	Yes	No	MRSA	Yes	No
Cancer	Yes	No	Osteopenia	Yes	No
Circulatory Problems	Yes	No	Osteoporosis	Yes	No
Currently Pregnant	Yes	No	Pace Maker	Yes	No
Depression	Yes	No	Respiratory Illness	Yes	No
Diabetes	Yes	No	Seizures/Epilepsy	Yes	No
Heart Attacks	Yes	No	Sepsis	Yes	No
Heart Disease	Yes	No	Shoulder Dislocation	Yes	No
Hepatitis	Yes	No	Special Diet Restrictions	Yes	No
Hernia	Yes	No	Stroke (CVA)	Yes	No
High Blood Pressure	Yes	No	Surgery to Head, Neck or Spine	Yes	No
Immune/ Deficiency	Yes	No			

MEDICATIONS, PLEASE LIST BELOW OR ATTACH YOUR LIST:

PREVIOUS HOSPITALIZATIONS OR SURGERIES, PLEASE LIST BELOW:

WHAT ARE YOUR EXPECTATIONS OR GOALS WHILE YOU ARE IN THERAPY?

I have read and filled out this questionnaire to the best of my knowledge.

 Patient Signature (Or Guardian)

 Date