REHAB SPECIFIC MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

Was there a specific injury? YES NO Date of injury or onset: _____

How did it occur? (accident, work, or other related)

_____

Nature of problem: (be as specific as possible)

_____

_____

Symptoms: (e.g. burning, dull ache, stabbing pain) _____

What relieves/aggravates your symptoms? _____

_____

Have you had this problem before? YES NO

Have you ever received treatment in the past for the condition bringing you to therapy? YES NO

If so, when and what treatments have you tried? (e.g. ice/heat/exercise) _____

_____

Occupation, usual activities and hobbies: _____

_____

Occupational demands: (lifting, walking, sitting) _____

MEDICAL HISTORY

Cancer	Y N	Seizures	Y N	Currently pregnant	Y N
Diabetes	Y N	Pacemaker	Y N	Allergies	Y N
Bowel/Bladder Change	Y N	Deep Vein Thrombosis	Y N	Fatigue/Weakness	Y N

Explain any past medical and surgical history that may affect your plan of care:

_____

_____

_____

Have you fallen in the last year? YES NO Last 3 months? YES NO

Do you have any cultural/spiritual beliefs that need to be considered for treatment? YES NO

At the present time, would you say that your health is (circle one) Excellent Good Fair Poor

What are your goals with therapy:

_____

_____

Signature: _____ Date: _____ Time: _____

Patient Label

Rehab Specific Medical History
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SCAN TO PT, OT or ST NOTE