



MEDICAL HISTORY

NAME: _____

DOB: _____

REASON FOR TREATMENT: _____

ONSET: _____

HAVE YOU HAD SURGERY ASSOCIATED WITH THIS PROBLEM? ___ no ___ yes

If yes, type? _____ Where? _____

When? _____

HAVE YOU HAD THERAPY FOR THIS PROBLEM BEFORE? ___ no ___ yes

If yes, type? _____ Where? _____

When? _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? (List All) _____

(Please notify Admissions of any changes in medications)

DO YOU HAVE / OR HAVE HAD, ANY OF THE FOLLOWING:

- High Blood Pressure ___ yes ___ no
Heart Disease ___ yes ___ no
Heart Attack ___ yes ___ no
Pacemaker ___ yes ___ no
Diabetes ___ yes ___ no
Headaches ___ yes ___ no
Kidney Problems ___ yes ___ no
Nervous Disorder ___ yes ___ no
Hearing Problems ___ yes ___ no
Are you pregnant? ___ yes ___ no
Sensitive to Heat/Ice ___ yes ___ no
Allergies ___ yes ___ no
Hernia ___ yes ___ no
Seizures ___ yes ___ no
Metal Implants ___ yes ___ no
Dizzy Spells ___ yes ___ no
Balance Problems ___ yes ___ no
Vision Problems ___ yes ___ no
Stroke / TIA ___ yes ___ no

(If yes to any of the above, please give approximate date in space provided)

LIST ANY OTHER MAJOR ILLNESS, SURGERY OR ACCIDENT THAT HAS OCCURRED IN THE PAST YEAR: _____

PLEASE GIVE FUNCTIONAL LEVEL IN THE FOLLOWING AREAS:

Table with 6 columns: Functional Area, Independent, Stand-By, Minimum, Moderate, Maximum. Rows include Ambulation, Transfers, Transportation, Domestic Chores, Shopping, Meal Preparation, Personal Care, Communication, Swallowing, and Other.

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature of Client/Guardian Date Witness Date