REHABILITATION PRE-EVALUATION HEALTH HISTORY

Name: ______________________________ **Date:** _____________ **Date of Birth:** _______________
TELEPHONE NUMBER: _________________________
Date of Injury/Surgery: __________ **If injury, cause of injury:** __________ **Next Dr. Visit**: _____________

To enhance the quality of evaluation and treatment, please provide us with the following important background information. This information will remain confidential, but will help to ensure a thorough and safe evaluation/treatment. Thank you for your cooperation.

Allergies:

Latex	Yes/No
Steroids	Yes/No
Adhesive	Yes/No
Other	Yes/No ____

Have you seen any of the following in the last 2 months for the current problem?

MD	Yes/No
PT	Yes/No
Chiropractor	Yes/No
Specialist	Yes/No
Other	Yes/No

Have you recently had any of the following diagnostic tests or interventions?

X-Rays	Yes/No	Doppler Study	Yes/No
MRI	Yes/No	Ultrasound	Yes/No
CT Scan	Yes/No	Steroid Injections	Yes/No
EMG	Yes/No		

If yes, please specify when: _______________________________
Other tests or interventions: Yes/No
If yes, please specify what and when: ______________________________________

Are you currently taking any prescription or over-the-counter medications? Yes/No
If yes, please list or provide a list of medications: ____
____
____
____

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Have you ever been diagnosed with any of the following?

Cancer	Yes/No	Heart Problems	Yes/No
High blood pressure	Yes/No	Pacemaker	Yes/No
Breathing problems	Yes/No	Diabetes	Yes/No
Stroke	Yes/No	Epilepsy	Yes/No
Arthritic conditions	Yes/No	Blood clots	Yes/No
Dizziness	Yes/No	Depression	Yes/No
Osteoporosis	Yes/No	MRSA Infection	Yes/No
High cholesterol	Yes/No	Other	Yes/No

Have you recently noted any of the following?

Unexplainable weakness	Yes/No	Fever/chills/sweats	Yes/No
Nausea/vomiting	Yes/No	Numbness/tingling	Yes/No
Bowel/bladder changes	Yes/No	Fatigue	Yes/No
Recent falls	Yes/No		

Other conditions/general health problems? Yes/No
If yes, please specify: ____

Previous Surgeries: Yes/No
If yes, please specify: ____
____

Have you been given any restrictions by your doctor? Yes/No
If yes, please specify: ____

Females Only:
Are you currently pregnant? Yes/No

Please use the following space to note any information regarding your general health history not asked in the previous questions.