GRAND VIEW HEALTH

Physical Medicine & Rehabilitation Department / Health & Wellness Center
Patient History and Health Information Form

Name: _____ Date: _____

Insurance: Please be sure to check with your insurance company before starting therapy.

Are you receiving **any** Home Care services at this time? ☐ Yes ☐ No

Have you received Therapy services at **any** facility in the past 12 months? ☐ Yes ☐ No

If **yes**, how many sessions did you attend? _____

Referral: Why did you choose Grand View Health for your Rehabilitation needs?

☐ Reputation ☐ Convenience/Location ☐ Doctor Recommendation

☐ Insurance ☐ Friend/Family Recommendation ☐ Other: _____

Social History:

Do you have any customs or religious beliefs that might affect your care? ☐ Yes ☐ No

If **yes**, please describe: _____

What is your occupation? _____

What is your work status? ☐ Full Duty ☐ Light/Modified Duty ☐ Retired
☐ Disabled ☐ Student ☐ Out of Work Due to Injury

With whom do you live? ☐ Alone ☐ Others: _____

Please describe your home: ☐ Single Story ☐ Two (or more) Stories ☐ Group Home

Do you need to climb stairs as part of your daily routine? ☐ Yes ☐ No

Do you have a history of falling? ☐ Yes ☐ No

Therapy Information:

Why are you coming for Therapy services? _____

What are your goals for Therapy? (Check all that apply)

☐ Improve Strength ☐ Improve Flexibility ☐ Improve Mobility ☐ Reduce Pain

☐ Reduce Swelling ☐ Improve Balance ☐ Return to Work ☐ Return to Sport

☐ Other: _____

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Name: _____ Date: _____

When did the problem(s) begin? Please be as specific as possible: _____

Are you seeing anyone else for the problem? ☐ Yes ☐ No

If **yes**, who: _____

Please list your medications: _____

_____

_____

Please list your allergies: _____

Please list any surgeries: _____

Medical History:

	Yes	No		Yes	No
Anemia	☐	☐	Emphysema/Bronchitis	☐	☐
Aortic Aneurysm	☐	☐	Hepatitis	☐	☐
Arthritis	☐	☐	High Blood Pressure	☐	☐
Asthma	☐	☐	Incontinence	☐	☐
Blood Clot	☐	☐	Kidney Problems	☐	☐
Broken Bones	☐	☐	Metal Implants	☐	☐
Cancer	☐	☐	Multiple Sclerosis	☐	☐
Cardiac Conditions	☐	☐	Osteoporosis	☐	☐
Cardiac Pacemaker	☐	☐	Parkinson's Disease	☐	☐
Cellulitis	☐	☐	Radiation Therapy	☐	☐
Circulation Problems	☐	☐	Rheumatoid Arthritis	☐	☐
Concussion/Head Injury	☐	☐	Seizures/Epilepsy	☐	☐
Congestive Heart Failure	☐	☐	Sensitive Carotid Sinus	☐	☐
COPD	☐	☐	Speech Problems	☐	☐
Currently Pregnant	☐	☐	Stroke	☐	☐
Depression	☐	☐	Thyroid Disease	☐	☐
Diabetes	☐	☐	Tuberculosis	☐	☐
Dizzy Spells/Vertigo	☐	☐	Vision Problems	☐	☐

Other medical problems: _____

When is your next doctor appointment? _____