

**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 Therapy goal is most important to you? (Please choose one)

 Improve Strength  Improve Flexibility  Improve Mobility  Reduce Pain

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

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3/27/15