Outpatient Rehabilitation Patient Information and Brief Medical History

Federal and State Regulations require a medical history must be included in the patient's medical records in this office

Date: ____________ Birthdate: ______________ OP Med Record#: _________

Patient Name: __________________________ Patient Phone #: _______________

Reason for Therapy Referral: ____

Date of Onset/Injury/Surgery: ___________________ Physician: ________________

Medical History:

Do you have/or have you had any of the following:

(Please place an X in any that apply)

Diabetes		Hernia		Headaches	
High Blood Pressure		Nervous Disorders		Visual Problem	
Circulatory Disorder		Are you pregnant?		Allergies	
Heart Disease		Sensitive to heat		Previous Surgeries	
Pacemaker		Sensitive to cold (ice)		Back Injury	
Metal Implants		Dizziness		Other Injuries	
Kidney Problems		Seizures		Other Illnesses	

If yes on any of the above, please explain and give approximate dates: ____________

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Medications:

Are you presently taking any medications? ☐ Yes ☐ No

If yes, please list what medications, dosage and for what condition:

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Other Information:

☐ Yes ☐ No Have you had previous therapy for the present condition for which you are to receive treatment here?

☐ Yes ☐ No Is this a work related injury or condition?

☐ Yes ☐ No Has the injury been reported to your employer?

The undersigned acknowledges and agrees that the information set forth herein is true and correct.

Date: ________________ Patient Signature: ______________________________

(If different from Patient) Responsible Party: ____________________________________