

ADVANCED THERAPY SOLUTIONS

PATIENT MEDICAL HISTORY

Name: _____ Referring Physician: _____
 Family Physician: _____ Date of First Doctor Visit for this Injury: _____
 Last Date Worked Due to this Injury: _____ Date Returned to Work After this Injury: _____
 Is an Attorney Involved in this Case? YES NO
 Have you had surgery for this injury? YES NO Number of Surgeries: 1 2 3 4 _____
 Type of Surgery: _____ Took Place In: Hospital Surgery Center

Are You Currently Taking Any Prescription or Non-Prescription Medications? YES NO
 Anti-inflammatories Muscle Relaxers Pain Medication
 List Medications: _____

Are you allergic to any medications? YES NO List Medications: _____

Have you had any of the following medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
Chiropractor	___	___	CT Scan	___	___
EMG/THERAPY	___	___	General Practitioner	___	___
Massage Therapy	___	___	MRI	___	___
Myelogram	___	___	Neurologist	___	___
Occupational Therapy	___	___	Orthopedist	___	___
Physical Therapy	___	___	Podiatrist	___	___
Emergency Room Care	___	___	X-Rays	___	___
Other: _____					

Do you now have, or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	___	___	Severe or Frequent Headaches	___	___
Shortness of Breath/Chest Pain	___	___	Vision or Hearing Difficulties	___	___
Coronary Heart Disease or Angina	___	___	Numbness or Tingling	___	___
Do you have a Pacemaker?	___	___	Dizziness or Fainting	___	___
High Blood Pressure	___	___	Bowel or Bladder Problems	___	___
Heart Attack or Surgery	___	___	Weakness	___	___
Stroke/TIA	___	___	Weight Loss/Energy Loss	___	___
Congestive Heart Disease	___	___	Hernia	___	___
Blood Clot	___	___	Varicose Veins	___	___
Epilepsy/Seizures	___	___	Allergies	___	___
Thyroid Disease or Goiter	___	___	Any Pins or Metal Implants	___	___
Anemia	___	___	Joint Replacement Surgery	___	___
Infectious Diseases	___	___	Neck Injury/Surgery	___	___
Diabetes	___	___	Shoulder Injury	___	___
Cancer or Chemotherapy/Radiation	___	___	Elbow/Hand Injury/Surgery	___	___
Arthritis	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Gout	___	___	Leg/Ankle/Foot Injury/Surgery	___	___
Sleeping Problems/Difficulties	___	___	Are you pregnant?	___	___
Emotional/Psychological Problems	___	___	Do you use tobacco products?	___	___

List any other information that would assist us in your care: _____

Are you aware of your diagnosis and prognosis as explained by your doctor? YES NO
 Based on your awareness, what are your rehabilitation expectations/goals while in this program?

Would you like to speak to a social worker about any aspects of your rehabilitation program? YES NO

Patient/Guardian Signature: _____ Date: _____