BERTRAND CHAFFEE HOSPITAL
Rehabilitation Services - Patient History

PLEASE ANSWER THE QUESTIONS BELOW TO THE BEST OF YOUR ABILITY:

Name: Date:

Primary Physician: Referring Physician:

Other specialists seen:

Height: Weight: Occupation:

Medications:

Do you currently take an anticoagulant or steroid medications?

Allergies:

Do you have a pacemaker? Y N Any metal implants?: Y N

If Yes, where?

Have you had any hospitalizations within the last year?

Any recent or related surgeries? Describe:

Do you have a health care proxy or do not resuscitate order? (circle)

Are you receiving any home care services? Y N

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

____ Heart disease	____ Epilepsy/Seizures	____ Fainting
____ Fracture	____ Neurological problems	____ Blood clots
____ High blood pressure	____ Numbness	____ Nausea/vomiting
____ Migraines/ Headaches	____ Diabetes	____ Muscle disease
____ Asthma/Breathing Disorder	____ Weakness	____ Skin infection/irritation
____ Shortness of breath	____ Tremor	____ Unexplained weight loss
____ Varicose veins	____ Cancer/tumor	____ Stroke
____ Neck or Back pain/surgery	____ Liver disease	____ Arthritis
____ Osteoporosis/Osteopenia	____ Circulation Problems	____ Current pregnancy

When did your current condition begin/surgery occur? _____

Does the condition for which you were referred here limit abilities or functions? Y N
If yes, please list major problem areas: _____

Have you had any procedures or tests for this condition? Y N Describe: _____

Have you received physical therapy in the past, for this or any other problems? _____ If yes, what treatments were administered? _____

What are your goals for treatment?

Upon completion of my physical therapy assessment, I understand the findings and proposed treatment regime, as explained by and discussed with the physical therapist. I understand the benefits of the proposed treatment or lack of treatment, the prognosis of meeting the goals of treatment and the alternatives associated with my care.
Based upon this information, I give my informed consent for treatment as proposed.

_____
Patient Signature