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

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Patient Signature