



# DEPARTMENT OF REHABILITATION PATIENT HISTORY

**PERSONAL INFO:** PATIENT'S NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ HAND DOMINANCE: { } Right Handed { } Left Handed

FIRST LANGUAGE: \_\_\_\_\_

**EMPLOYMENT:** Circle which of the following apply to you:

Retired Full Time Part Time Work w/ Restrictions Not Working Worker's Compensation Other \_\_\_\_\_

Occupation: \_\_\_\_\_

Current Employer: \_\_\_\_\_

DATE OF INJURY/ONSET: \_\_\_\_\_ WORK RELATED: YES NO NUMBER OF MONTHS OFF WORK: \_\_\_\_\_

### HISTORY:

1. Specifically, what is your present problem or complaint? \_\_\_\_\_

2. How did this happen? (accident, etc.) \_\_\_\_\_

3. Have you ever had anything similar before? { } Yes { } No If yes, explain: \_\_\_\_\_

4. If yes, did you receive any treatment for it? { } Yes { } No { } N/A Did it help? \_\_\_\_\_

5. What would you like to gain from therapy? \_\_\_\_\_

### PAST MEDICAL HISTORY:

1. Have you had any serious injuries, operations, or hospitalizations? Yes No If yes, please list and give dates: \_\_\_\_\_

2. Do you now have or have you ever had any of these conditions?

	Yes	No	Please explain:
High Blood Pressure	_____	_____	_____
Diabetes	_____	_____	_____
Heart Problems (e.g. heart attack, heart failure)	_____	_____	_____
Lung Problems (e.g. asthma, COPD, Emphysema)	_____	_____	_____



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Do you now have or have you ever had any of these conditions?

	Yes	No	Please explain:
Liver Problems (e.g. hepatitis, etc.)	_____	_____	_____
Kidney and/or Bladder Control	_____	_____	_____
Skin Problems (e.g. Rash)	_____	_____	_____
Neurological Problems (e.g. strokes, Parkinson's, M.S., brain injury, seizures)	_____	_____	_____
Contagious Disease	_____	_____	_____
Mental Illness	_____	_____	_____
Memory Loss	_____	_____	_____

Anything else we should be aware of? \_\_\_\_\_

3. Are you currently taking any medications:  Yes  No  See attached list

If so, please list: \_\_\_\_\_  
\_\_\_\_\_

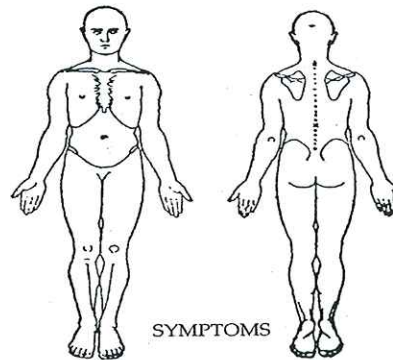
4. Do you have any drug allergies?  Yes  No If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

5. Do you smoke?  Yes  No If yes, how much? \_\_\_\_\_

6. If you are a female, is there any possibility that you are pregnant?  Yes  No

7. If you have pain, please circle the word(s) below that best describes your pain.

Pulsing	Tingling	Aching	Intense
Throbbing	Shooting	Dull	Exhausting
Pounding	Sharp	Sore	Miserable
Quivering	Burning	Tender	Nauseating



Mark the location(s) of your symptoms on the body picture

**I certify that I have reviewed the preceding health information with the patient:**

**Therapist's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parkview Adventist Medical Center  
Brunswick, Maine 04011

RSD005-0407 (04-09-07)

PATIENT IDENTIFICATION



R S D 0 0 5

THIS FORM IS A MEDICAL RECORD