Springs Rehabilitation Patient History Form

Date: _____

NAME: _____ AGE: _____

What medical problem brings you to our clinic?

When did this begin?

What do you think caused it? (Circle One): Work Injury Auto Accident Other

Please describe:

What **treatment(s)** have you had for this problem so far?

What **percent improvement** have you had since onset (0-100%)? _____%

On a scale in which 0 is no pain and 10 is the worst pain you can imagine, please rate your pain:

Today (0-10): _____ Best (0-10): _____ Worst (0-10): _____Usually (0-10): _____

How long can you: Sit: _____ Stand: _____ Walk: _____ Drive: _____

How much do you think you can currently lift? _____lbs.

Please list all the **medications** and their dosages you take (including non-prescription drugs).
Circle any which have been causing difficulties.

DRUG NAME	**DOSAGE**	**HOW OFTEN**

Have you received a Pneumonia Vaccine within the past year? YES NO Approx. Date _____

Please list all known drug **allergies**: (If none, please circle NONE)

DRUG	**REACTION**	**NONE**

PAST MEDICAL HISTORY:

Have you had any **previous injuries or problems** to areas that we are seeing you for today?

Please list all **previous hospitalizations** and the reason for treatment:

HOSPITAL NAME	DATE	TREATMENT

GENERAL MEDICAL: Have you had any of the following? (Please circle)

Yes	No	Heart Problems
Yes	No	High Blood Pressure
Yes	No	Lung Problems
Yes	No	Liver Disease
Yes	No	Ulcers
Yes	No	Kidney Problems
Yes	No	Cancer
Yes	No	Diabetes
Yes	No	Stroke
Yes	No	Any Disease of the Nerves or Muscles
Yes	No	AIDS or Related Diseases (HIV positive)
Yes	No	Psychiatric Treatment
Yes	No	Drug or Alcohol Problems or Rehab

Yes	No	Any family members who were disabled from work?
Yes	No	Any blood relatives who have arthritis?
Yes	No	Any blood relatives who had heart attacks before age 55?
Yes	No	Any blood relatives who have a nerve or muscle disease?

Other medical problems not noted above **(PLEASE LIST):**

Signature_____ DOB_____

SOCIAL HISTORY:

Marital Status (Please Circle): Single Married Divorced Widowed Separated

Employment (Please Circle):

Employed	Student
Self-Employed	Homemaker
Retired	Unemployed

If Employed: Where?_____ How long in this position?_____

What is your job title?_____

What are your specific job duties?_____

Have you had a drink containing alcohol in the past year? YES NO

How many alcoholic drinks do you have per week?_____ Per Month? _____

On a typical day that you have a drink, how many do you drink? _____

Are you a current smoker? YES NO Do you smoke everyday? YES NO

How many Cigarettes per day?_____

How soon after you wake up do you smoke your first Cigarette?_____

Are you interested in quitting smoking? YES NO

Are you a former smoker? YES NO How long ago did you quit?_____

Do you use street drugs? YES NO

Do you use Marijuana Products? YES NO (Circle one) medicinal or recreational How much?_____
How Often?_____
What Type? (Circle One) Smoke Edible Hash Oil

Aside from this problem, what is the most stressful thing in your life?

HEALTH MAINTENANCE:

How often do you exercise? (Please Circle One)

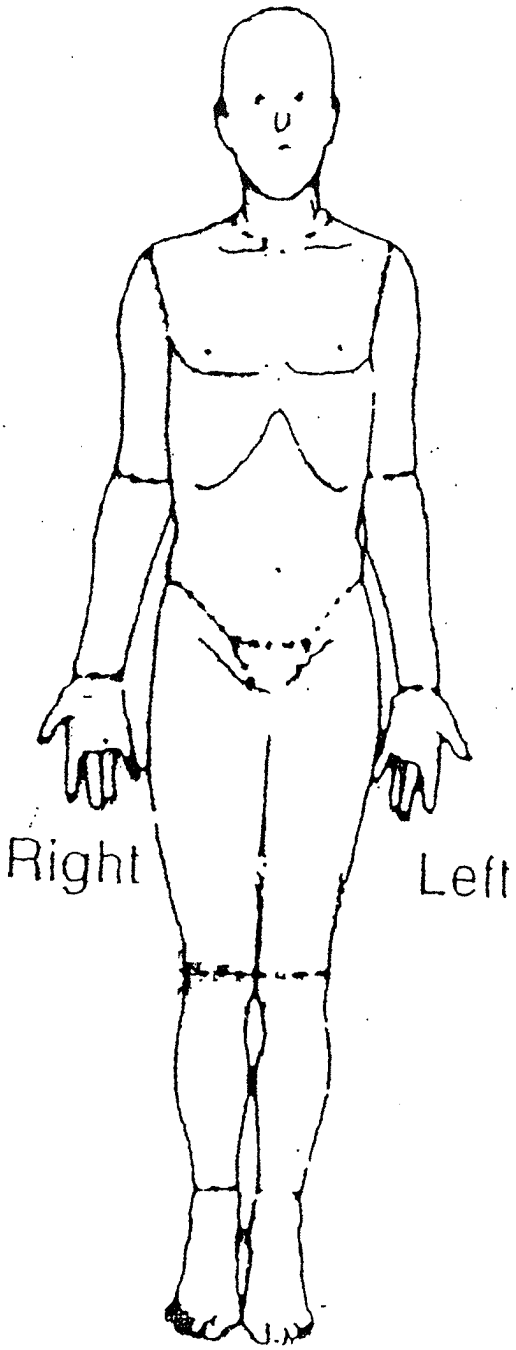
Daily 3 or more times a week Once a week Seldom Never

What kind of exercise?

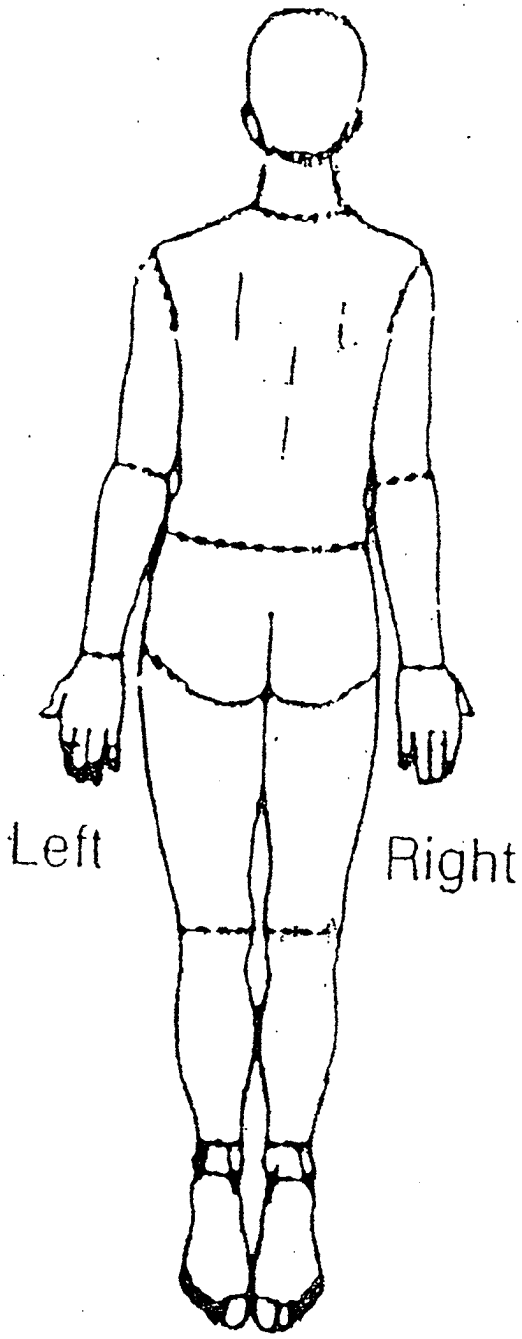
Signature_____ DOB_____

Mark the areas on your body where you feel these sensations.
Please use these Symbols:

Numbness	Pins and Needles	Ache	Pain
= = = = =	o o o o o	x x x x	/ / / /
= = = = =	o o o o o	x x x x	/ / / /
= = = = =	o o o o o	x x x x	/ / / /



Anterior



Posterior

DOB

SIGNATURE

CIRCLE ANY SYMPTOMS YOU HAVE HAD RECENTLY:

General:
Fever/Chills Sweats Weight Loss (without trying)
Fatigue/Poor Energy Level Poor Appetite Poor Sleep Hoarse Voice

Cardiovascular:
Chest Pain with exercise Chest Pain at rest Irregular Heartbeat
Shortness of Breath Leg Swelling Cold/Blue Feet

Respiratory:
Persistent Cough Blood in Sputum

Gastrointestinal:
Belly Pain Heartburn Nausea/Vomiting Blood in Stool
Hemorrhoids Constipation Diarrhea Bowel Incontinence

Genitourinary:
Pain with Urination Difficulty Starting Stream Bladder Accidents/Incontinence
Blood in Urine Urinary Tract Infection Abnormal Vaginal Bleeding
Breast Discharge or Mass

Rheumatologic:
Morning Stiffness Joint Swelling Skin Sore Rash Calluses

Neurologic:
Headaches Blackouts Dizziness Seizures Tremor
Numbness or Tingling (Where?)_____ Weakness (Where?)_____
Poor Memory Decreased Coordination Blurred Vision
Mood Swings

Hematologic:
Easy Bruising or Bleeding

Endocrine:
Frequent Thirstiness Frequently Feeling Cold

Psychological:
Feelings of: Depression Anxiety Stress

Please Sign: _____ DOB_____

Reviewed with Patient: _____