

Southeastern Fitness and Rehabilitation

Patient Medical History

Name: _____ Referring Physician: _____

Family Physician: _____ Date of first Doctor Visit for this Injury: _____

Last Date worked Due to 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: _____

Are you currently taking any Prescription or Non-Prescription Medications? Yes No

Anti-inflammatory _____ 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/NCV	_____	_____	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	_____	_____	Vision or Hearing Difficulties	_____	_____
Shortness of Breath/Chest Pain	_____	_____	Numbness or Tingling	_____	_____
Coronary Heart Disease or Angina	_____	_____	Dizziness or Fainting	_____	_____
Do you have a Pace Maker?	_____	_____	Bowel or Bladder Problems	_____	_____
High Blood Pressure	_____	_____	Weakness	_____	_____
Heart attack or Surgery	_____	_____	Weight Loss or Energy Loss	_____	_____
Stroke/TIA	_____	_____	Hernia	_____	_____
Congestive Heart Disease	_____	_____	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/Surgery	_____	_____
Cancer or Chemotherapy/Radiation	_____	_____	Elbow 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?	_____	_____

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: _____