Orthopedic Care Specialists
Rehab Department

To ensure that you receive a complete and thorough evaluation, please provide us with important background information. Thank You.

Patient Name _____ Date of Birth_____ Age_____

Height: _____ Weight:_____

Diagnosis / Area Being Treated _____Date of Injury / Onset of Pain_____

Have you had any diagnostic tests related to this injury?

□ X-Ray □ MRI □ CT Myelogram □ EMG/ NCS □ Bone Scan

Have you ever been treated by a Physical Therapist / Occupational Therapist for this injury?

□ Yes □ No If yes, please explain _____

_____

Are you undergoing or have you undergone any other treatment for this injury (for example chiropractic, injections, massage)? □ Yes □ No If yes, please explain _____

_____

Medical History: Please review the list below. If you have now, or have had in the past, a problem in any of these areas, please check "YES" and explain in the space provided. If not check "NO".

	YES	**NO**		**YES**	**NO**
Heart disease			Asthma/Allergies		
Angina/Chest Pain / Heart Attack			Lung disease (Emphysema, Bronchitis, COPD)		
High blood pressure			Hepatitis/Liver disease		
Heart murmur			Kidney disease		
Diabetes			Thyroid disease		
High Cholesterol			Anemia/Abnormal bleeding		
Gastrointestinal disease			Depression/Anxiety		
Stomach ulcers			Other psychiatric condition		
Seizures/Epilepsy/Stroke			Arthritis		
Mitral valve prolapse			Fibromyalgia		
HIV/AIDS			Cancer: If yes what type:		

Orthopedic Care Specialists
Rehab Department

Surgeries: Please list any surgeries you have had: (Include the date of the surgery).

Surgery Type	Date

Injuries: Please describe any injuries you have been treated for (fractures, dislocations, sprains) and approximate dates.

Injury	Date

Medications: Please list all the medications you are currently taking: including prescription drugs, inhaler, aspirin products, non-steroidal anti-inflammatory drugs, eye drops, supplements, vitamins, over-the-counter medications and non-prescription drugs.

Medications	

Allergies: Please list allergies, sensitivities, medication reactions: include medications; vaccinations; foods; insects/venom, such as bee sting; substances, such as latex; environmental allergies; seasonal allergies; reactions, including iodine or radiology contrast material.
I have no known allergies, sensitivities or medication reactions: (please initial)_____

Allergy/Sensitivity/Medication	Type of reaction:

Orthopedic Care Specialists
Rehab Department

Review of Systems:

Are you healthy?	□ Yes	□ No
Have you lost or gained weight (without changes in diet /exercise)?	□ Yes	□ No
Do you have any swelling?	□ Yes	□ No
Have you had any recent fevers?	□ Yes	□ No
Do you have any palpitations?	□ Yes	□ No
Do you have any difficulty breathing / shortness of breath?	□ Yes	□ No
Do you have frequent headaches?	□ Yes	□ No
Have you had any recent changes in vision or hearing?	□ Yes	□ No
Have you had any problems with balance or any falls?	□ Yes	□ No
Are you pregnant?	□ Yes	□ No

Social History:

Are you currently working? □ Yes □ No Occupation: _____

Job Description: _____

What is your goal(s) for coming to therapy? _____

_____

PATIENT CERTIFICATION:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes on my medical status.

Signature _____ Date _____
Patients or Responsible Party

CLINICIAN REVIEW:
I have reviewed the above information with the patient.

Clinician's Signature: _____ Date: _____

Print Name: _____