HERSHEY ORTHOPEDIC & SPINE REHABILITATION

Medical History Form

Name: (Please Print): _____ **Age:** _____ **Date:** _____

INSURANCE REQUIRES US TO DOCUMENT THIS INFORMATION SO PLEASE ANSWER ALL OF THE QUESTIONS BELOW TO THE BEST OF YOUR ABILITY:

1. Briefly explain what happened (accident, injury, illness etc) that caused you to come to Physical Therapy? _____

2. **WHEN** did this happen? (give approximate date): _____

3. Please list all the things you can't do or have difficulty doing because of your condition:
   _____
   _____
   _____

4. Please list **ALL MEDICATIONS** you are taking (if you don't know the names, please list the type): _____
   _____

5. Please list any **ALLERGIES** (medication, food, environmental) that you have:
   _____
   _____

6. Check off all the following that you have or have ever had in the past:

_____ High Blood Pressure	_____ Pacemaker	_____ TB/tuberculosis
_____ Heart Condition	_____ Seizures	_____ Cough > 2 weeks
_____ Stroke	_____ Cancer	_____ Fever > 2 weeks
_____ Diabetes	_____ Falls/Imbalance	_____ Unexplained weight loss
_____ Dizziness	_____ Night Sweats	_____ Lyme's Disease

7. Please briefly list all **SURGERIES**:

_____
_____
_____

8. Have you had any special tests recently (MRI, CT-Scan, X-rays, etc.)? Yes ____No____
   If you answered yes, please list the test and results:

_____
_____
_____

9. **WOMEN ONLY**: Are you pregnant now, or is there a chance you may be pregnant?
   No____ Yes___

10. At the present time, how would you say your health is: (Circle one)

    Excellent Very Good Fair Poor

11. Have you had any Physical Therapy for the same condition elsewhere?
    Yes_____ No_____
    If you answered yes, please list the clinic, year and how many visits (approximately) that you had: _____

12. Are you receiving any other care? Please circle all those that apply:

OT-Occupational Therapy SLP-Speech Therapy Chiropractic Nursing care
Radiation treatments Chemotherapy

Other: _____

13. Have you been discharged from a rehabilitation facility, skilled nursing facility or home health recently? Yes_____ No_____

If you answered yes, please list the date you were discharged:_____

14. Do you use any medical equipment? (Cane, walker, wheelchair etc) Yes_____ No_____

If you answered yes, please provide a brief list of equipment that you have: _____
_____

15. Has this illness/injury/accident caused you to miss time working? Yes _____ No_____

16. Have you ever had an injury that prevented you from working? Yes_____ No _____

If you answered yes, please explain: _____
_____

I certify that my answers to the above questions are correct and true to the best of my knowledge:

Signature:_____