NEW REHABILITATION SERVICES

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CONFIDENTIAL HEALTH REPORT

PATIENT NAME_____ DATE_____

What is the primary complaint that brings you in for treatment (example – pain, stiffness, weakness, ect.)_____
_____

What diagnosis (if any) has your doctor given for your condition? _____
_____

How and when did your condition start or begin? _____
_____

Where is the location of the problem (left, right, center)?

LOCATION	RIGHT	LEFT	CENTER
SHOULDER			
UPPER ARM			
ELBOW			
FOREARM			
WRIST			
HAND			
HIP			
THIGH			
KNEE			
LEG			
ANKLE			
FOOT			
HEAD			
NECK			
BACK			
CHEST			
ABDOMEN			
RIB CAGE			

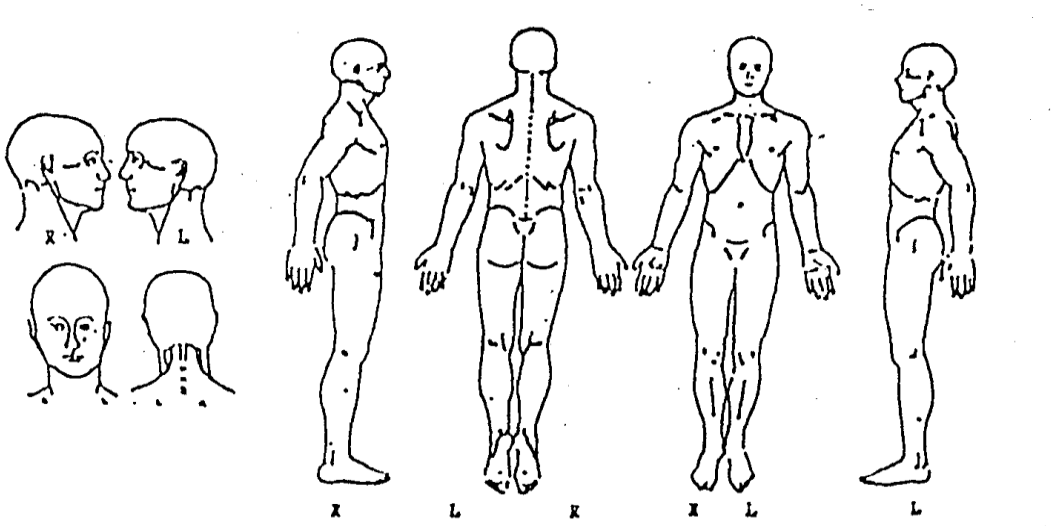
Please indicate on the sketch below, where you experience pain. If the pain radiates, (moves from one area co another) please indicate the direction of movement. Comments

_____

_____

How do you rate your pain right now? 1 being the least, 10 being the most.

1 2 3 4 5 7 8 9 10



How would you describe your pain? Please check all that apply.

Sharp	Prickly	Dull	Starts Suddenly	Starts Gradually	In Joints	Aching

Throbbing	On & Off	Burning	Stops Suddenly	Stops Gradually	Constant

When does the pain bother you the most? Please check all that apply.

Lying in Bed	Bending	Carrying	Standing	Twisting	Driving

Sitting Lifting	Lifting	Riding in Car	Work	Home	Eating

MEDICAL HISTORY

Do you have a pace maker? ___yes ___no

Are you ___Right Handed ___Left Handed

Do you wear dentures? ___yes ___no If yes, ___upper ___lower How often? _____

Do you wear contact lenses? ___yes ___no

Do you have prosthetic joints? ___no ___yes, where? _____

Are you aware of having, or have you been diagnosed as having any of the following conditions?
___Allergies ___Arthritis ___Asthma ___Carpal Tunnel ___Diabetes
___Emphysema ___Fibromyalgia ___Headaches ___High Blood Pressure
___Long Second Toe ___Obesity ___Menstrual Cramps ___Osteoporosis
___Phlebitis ___Round Back ___Round Shoulders ___Scoliosis ___Sway Back
___TMJ ___Insomnia ___Underweight ___Varicose Veins ___Corns
___Calluses ___Web Toes ___Bunions

Do you ever experience any of the following?

EARS	___Ringing	___Pressure	___Fullness	___Blockage
JAW/MOUTH/TEETH	___ Grating	___Snapping	___Clenching	
	___ Popping	___Grinding	___Difficulty Opening	
OTHER	___Dizziness	___Fainting	___Nausea	___Nervous Tics

Please list all surgeries; please include all minor procedures such as tonsillectomy, or orthodontics.
DATE_____SURGERY_____
DATE_____SURGERY_____
DATE_____SURGERY_____

Please list all previous injuries/accidents/broken bones that required medical attention.
DATE_____INJURY_____
DATE_____INJURY_____
DATE_____INJURY_____

Please give the date and location of your most recent:
X-RAY_____
MRI_____

Please list all current medications you take.
MEDICATION_____DOSAGE/MG_____
MEDICATION_____DOSAGE/MG_____
MEDICATION_____DOSAGE/MG_____
MEDICATION_____DOSAGE/MG_____

What are your pain management and personal wellness goals?

_____
_____
_____

NOTES: