FAUQUIER HEALTH

Rehabilitation Services Medical History

Name:_____Height:___ft.___in. Weight: _____lbs

Describe the reason for your therapy visit: _____

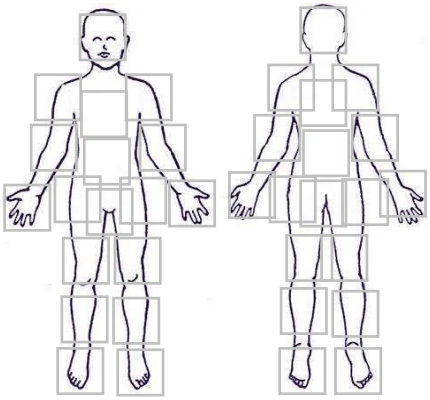
_____

How and when did the injury/problem occur? Date:_____

_____

Have you had any previous or similar problems? ☐ Yes ☐ No

Do you have pain? ☐Yes ☐No If yes, please indicate the location of your pain on the drawing below:



Please describe your pain:

☐ Dull	☐Burning
☐ Sharp	☐Constant
☐ Throbbing	☐Intermittent
☐ Bruised	☐Other:_____
☐ Sore	

No pain ☐ **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** Worst Pain

Mark an X on the line above in the area which best indicates your current pain level.

Have you had any of the following in regard to this condition?

☐ X-ray ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ Other: ____

Have you had any falls in the past 14 days or do you have concerns about falling? ☐ Yes ☐ No. If Yes, how many/resulting injuries? _____

Do you live alone? ☐Yes ☐No. If no, who do you live with?_____
Do you have a caregiver? ☐ Yes ☐ No
Do you have stairs? ☐Yes☐No If yes, how many? _____ Railings? ☐Yes ☐No

What is your preferred language? _____ What is your primary language? _____

Preferred Method of learning? ☐Discussion ☐Demonstration ☐Handout/Packet ☐Audiovisual ☐Written

Any cultural, ethnic, or spiritual concerns regarding your care? _____

What is your occupation?_____
Are you working? ☐Yes☐ No If no, is it due to this injury? ☐ Yes ☐No

Please check if you are currently seeing any of the following: ☐ Medical Doctor ☐ Osteopath ☐ Dentist
☐ Psychiatrist/Psychologist ☐Physical Therapist ☐ Chiropractor

Are you currently experiencing Abuse/Neglect in your life? ☐ Yes ☐ No. Comment:_____
Are you currently experiencing thoughts of hurting yourself or others? ☐ Yes ☐ No _____

Therapist Signature:_____ Date:_____ **NEXT PAGE** ⇨

FAUQUIER HEALTH

Please list any surgeries or conditions for which you have been hospitalized. Include the approximate date & reason for the hospitalization: (for example: Dec/2013 total joint replacement)

Date	Reason for Hospitalization	Date	Reason for Hospitalization

Please describe injuries for which you have been treated (For example: Fractures, sprains, strains,etc.)

Injury	Treatment	Injury	Treatment

Have you ever been diagnosed with any of the following?

☐Cancer
☐Heart Problem
☐High Blood Pressure
☐Pacemaker/internal defibrillator
☐Anemia
☐Asthma
☐Emphysema/COPD
☐Chemical Dependency
☐Thyroid Problem
☐Diabetes
☐Multiple Sclerosis
☐Depression
☐Hepatitis
☐Tuberculosis
☐Osteoporosis/Osteopenia
☐Kidney Disease
☐Epilepsy
☐Stroke
☐Rheumatoid Arthritis
☐Other Arthritic Condition
☐Other _____

Do you have any food/drug/LATEX allergies? ☐ Yes ☐No If Yes, describe:_____

Are you currently pregnant? ☐Yes ☐No, If no, are you currently breastfeeding? ☐Yes ☐No

How many cups of caffeine containing beverages do you drink per day? _____
How many packs of cigarettes do you smoke per day? _____
How many days per week do you drink alcohol? _____

Please provide a list of all medications you are currently taking:

Medication	Dosage	Medication	Dosage

Patient Signature:_____ Date:_____

Therapist Signature:_____ Date:_____

FAUQUIER HEALTH *PMR*
INTAKE FORM – DEC 2016

Patient Information