Carter Rehabilitation & Aquatic Centers

MEDICAL HISTORY FORM

Please fill this form out, print, and turn in at your first appointment.

Name:_____ Age:_____

Area of Symptoms:_____

Date Symptoms Started:_____

Please take a moment to complete the questions below. Depending on your answers, we may modify treatment procedures for their effectiveness and you safety.

Any known results of recent X-rays or tests:_____

Chronic Conditions: ☐Yes ☐No if yes, please list: _____

Medications: ☐Yes ☐No if yes, please list:_____

Allergies: ☐Yes ☐No if yes, please list:_____

Latex Sensitive: ☐Yes ☐No

List surgeries and dates: _____

Do you or have you had any of the following:

Cancer	☐Yes	☐No	High Blood Pressure	☐Yes	☐No
Diabetes	☐Yes	☐No	Metal Implants	☐Yes	☐No
Epilepsy/Seizures	☐Yes	☐No	Respiratory Problems	☐Yes	☐No
Heart Disease	☐Yes	☐No	Hepatitis	☐Yes	☐No
Tuberculosis	☐Yes	☐No	Are you pregnant?	☐Yes	☐No

1. How would you rate your ability to perform your routine daily activities?

(no problems) ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (unable to perform)

2. How would you rate your ability to perform the activities associated with your job?

(no problems) ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (unable to perform)

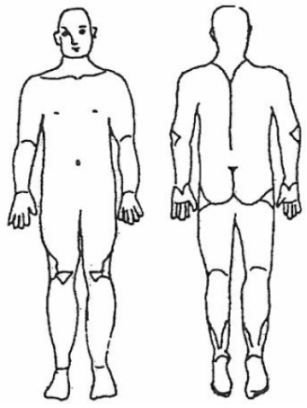
3. How many days since your current injury? ☐0-30 days ☐31-90 days ☐91+ days

How did you select our service?

☐Doctor recommendation	☐Previous patient	☐Ad in phone book
☐Insurance provider directory	☐Family/Friend recommended	☐Internet Search
☐Radio	☐Newspaper	☐Other_____

Please draw your pain on the body to the right using the following symbols: <u>Please do so after you print this form out.</u>

///	Stabbing Pain
xxx	Burning Pain
ooo	Pins and Needles
= = =	Numbness



_____ _____

Patient Name Date