Name: ____________________ Date: ____________

To assist your therapist, please complete your medical history as accurately as possible.

1. Physician that referred you to therapy: ____________________
   Date physician referred you to therapy: ____________________
   Date you return to physician that referred you to therapy: ____________________
   Have you had therapy for this problem previously? ☐Yes ☐No
   How long ago? ____________________
   Did therapy help? ____________________

   Have you had Occupational, Physical, or Speech Therapy at any time this calendar year?
   ☐Yes ☐No
   If "Yes", which services did you receive? ☐Occupational ☐Physical ☐Speech
   What months did you receive services? ____________________
   At what facility? ____________________

2. Please check all ***Medical Conditions*** that apply to you personally:

☐ Diabetes	☐ High Blood Pressure	☐ COPD	☐ High Cholesterol	☐ Cancers
☐ Pacemaker or Defibrillator	☐ History of Heart Conditions	☐ Arthritis	☐ Venous Insufficiency (Swollen Legs)	☐ Vertigo/Dizziness
☐ CVA / Stroke	☐ Depression or Anxiety	☐ Chronic Pain for more than 6 months	☐ Smoker or use of tobacco products	☐ Overweight

☐ Other: ____________________

____

3. Please list all ***Medications*** you are currently taking, please include *doses and reason* you are taking medication (i.e., anti-inflammatory, pain medication, blood pressure medication, diabetes medication, herbal and over-the-counter medications, etc.). If you have a list of your current medications, please bring it so that we can make a copy of it.

Medication	Dose	Reason you are taking this medication

4. Please list all ***Allergies*** (bee stings, medication, latex, environmental materials, etc):
   ____
   ____
   ____

OVER

Name: ____ Date: __________________

5. Have you ever had any ***Surgeries***? ☐Yes ☐No
   If 'Yes' please list type of surgeries and approximate date:
   ____
   ____
   ____

6. Have you ***Fractured/Broken*** any bones in the past? ☐Yes ☐No
   If 'Yes' please list:
   ____
   ____
   ____

7. Have you had any of the following ***Tests*** relating to your reason for coming to therapy?
   ☐X-Ray ☐MRI ☐Bone Scan ☐CAT scan ☐EMG/NCV
   Other: ____

8. ***General Mobility*** Questions:

   Have you fallen in the past 6 months? ☐Yes ☐No If "Yes", how many times? ______

   Do you walk with an assistive device? ☐Yes ☐No
   If "Yes" check which device(s) you use:

   ☐Cane ☐Quad Cane ☐Walker *with* wheels ☐Walker *without* wheels

   ☐ Other: ____

   Do you have trouble getting up out of a chair? ☐Yes ☐No

   Do you have trouble going up and down stairs? ☐Yes ☐No

9. What type of ***Education*** do you prefer? (Please check below)

   ☐ Audio ☐ Visual ☐ Combination ☐ One on One

10. Please list any other ***Medical Concerns*** you may have about your treatment:
    ____
    ____
    ____
    ____
    ____

Bradford Regional Medical Center – Bradford, PA 16701

REHABILITATION SERVICES
PAST MEDICAL HISTORY

(old #:7380-224 5/99)
Rvsd. 07/31/12

Form #: 3003435

Patient Identification Information