Great Northern Rehab

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. ***Thank you!***

Name:_____ Leisure Activities:_____

Age:_____ Occupation:_____

ALLERGIES: List any medication(s) you are allergic to:_____

Are you latex sensitive? Yes No List any other allergies we should know about:_____

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes No

Do you have a pacemaker? Yes No

Please check (√) any of the following whose care you're under

___Medical doctor (MD) ___Psychiatrist/Psychologist Other_____
___Osteopath ___Physical Therapist _____
___Dentist ___Chiropractor

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc…)

_____
_____

Have you **EVER** been diagnosed as having any of the following conditions?

YES NO Cancer. If YES, describe what kind:_____
YES NO Heart Problems
YES NO High Blood Pressure
YES NO Circulation Problems
YES NO Asthma
YES NO Emphysema/Bronchitis
YES NO Chemical Dependency (i.e. alcoholism)
YES NO Thyroid Problems
YES NO Diabetes
YES NO Multiple Sclerosis
YES NO Rheumatoid Arthritis
YES NO Other Arthritic Conditions
YES NO Depression
YES NO Infections (positive blood test for Hepatitis, HIV, AIDS)
YES NO Tuberculosis
YES NO Stroke, TIA
YES NO Kidney Disease
YES NO Anemia
YES NO Epilepsy
YES NO Other

For Office Use

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO
FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

	DATE	REASON FOR SURGERY/HOSPITALIZATION
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

OVER→

Great Northern Rehab

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	INJURY	DATE	INJURY
_____	_____	_____	_____
_____	_____	_____	_____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

YES NO Diabetes
YES NO Tuberculosis
YES NO Heart disease
YES NO High blood pressure
YES NO Stroke
YES NO Kidney disease
YES NO Alcoholism (chemical dependency)
YES NO Cancer
YES NO Arthritis
YES NO Anemia
YES NO Headaches
YES NO Epilepsy
YES NO Mental illness

Which of the following **OVER-THE-COUNTER** medications have you taken in the last week?

YES NO Aspirin
YES NO Tylenol
YES NO Advil/Motrin/Ibuprofen
YES NO Laxatives
YES NO Decongestants
YES NO Antihistamines
YES NO Antacid
YES NO Vitamins/mineral supplements
YES NO Other_____

For Office Use

Please list any **PRESCRIPTION** medication you are currently taking (INCLUDING pills, injections, and/or skin patches/cream):

1._____ 2._____ 3._____

4._____ 5._____ 6._____

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

How many packs of cigarettes do you smoke a day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

Have you recently noted:

YES NO Weight loss/gain
YES NO Nausea/vomiting
YES NO Fatigue
YES NO Weakness
YES NO Fever/chills/sweats
YES NO Numbness or tingling

For Office Use

_____ _____
Signature **Date**

_____ _____
Therapist Signature **Date**