Everest Rehabilitation Services
PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **Phone:**_____ **E-mail:** _____
Date of Birth: _____ Age: _____ Height: _____ Weight: _____
Referring Physician's Name (if applicable): _____
I am currently: Employed / Employed with restrictions / Unemployed / On medical leave / Retired
Work Status: Full Time / Part Time / Per-diem Job Position/Title: _____
Primary Care Physician's Name: _____ Phone: _____
Next Scheduled Doctor's appointment: Date _____ Physician _____
Date _____ Physician _____

Have you ever received Physical/Occupational therapy before? Yes / No Where? _____
Why? _____When? _____ How long? _____ What was the result? _____
What is your MAIN complaint today? _____
Date of Injury/ onset: _____ Cause of Injury/ onset: _____
What specific activities are you currently having difficulty with?

1. _____
2. _____
3. _____

What personal goals or outcomes do you expect from therapy?

1. _____
2. _____
3. _____

GENERAL HEALTH
Check all that apply, please list the year of the illness:

__Anemia	__Fainting	__Lung problem	__Tingling
__Anxiety	__Fracture _____	__Kidney problem	__numbness
__Arthritis _____	__Gout	__Stroke _____	__Skin disease
__Back injury	__Hearing problem	__Parkinson	__Vertigo
__Head Injury _____	__Headache	__Osteoporosis	__Imbalance
__Cancer _____	__Heart problem	__Pacemaker _____	__Thyroid problem
__Depression	__Hernia	__Mental illness	
__Diabetes	__Hepatitis	__Metal implant _____	
__Dizziness	__High blood pressure	__Incontinence (Urinary/ Bowel)	
__Epilepsy/Seizure _____	__Low blood pressure	__Recent Fall(s) ____within 1 year	

__I currently do NOT have any of the above conditions

Any other medical problems/ past surgeries/ hospitalization (List the date if possible):
_____
_____
_____
Do you smoke? Yes / No How many pack(s) per day? _____
Do you drink alcohol? Yes / No How often? _____
Do you take recreational drugs/substance? Yes / No What type? _____
Is there any chance you might be pregnant? Yes / No How many months? _____

To the best of my knowledge, the above information is complete and factual.

_____ _____
Patient's Signature Date

ALLERGIES & MEDICATIONS FORM

Patient Name: _____ Today's Date: _____

The medication(s) that you are taking is/are part of your health information. Please fill out this form (or have your caregiver complete it). If you need more space, please ask for another form.

Allergies

Name of substance (drug or food)	Type of reaction

Do you react to latex or rubber (gloves, balloons etc) with a rash, wheezing, etc? Yes / No

Current Medications

Prescription/over-the counter/ supplementary Drugs	Dosage	How Often? (i.e 3 times per day or as needed)	Who prescribed?

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone: _____

_____ _____

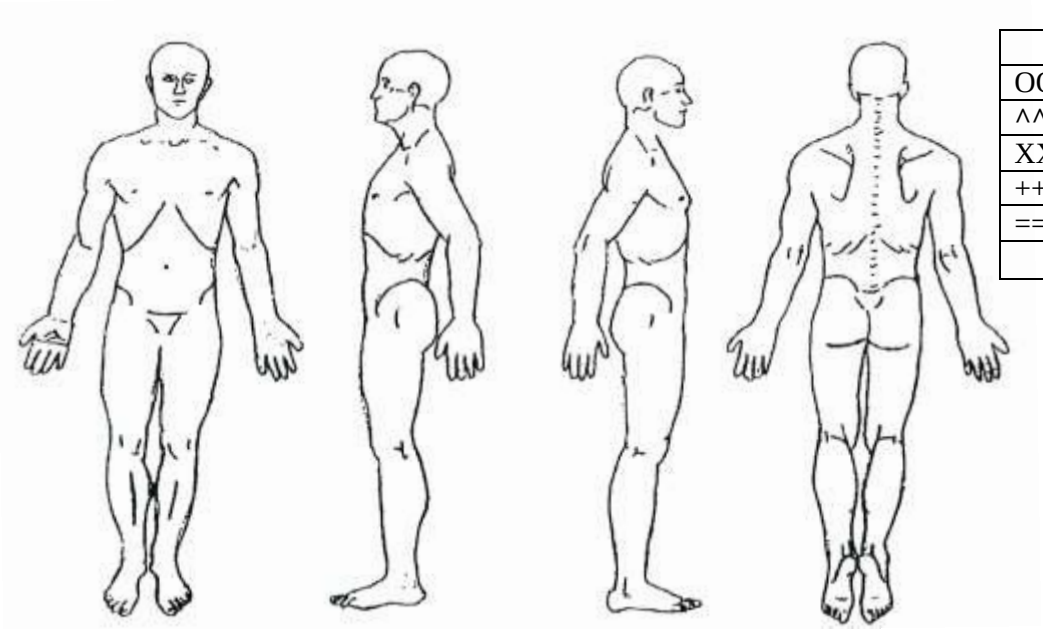
Patient's Signature Therapist's Signature

PAIN ASSESSMENT FORM

Patient Name: _____ Today's Date: _____

____ Initial visit _____ Follow up

Use the key below to mark or shade the areas of the body where you feel pain or have problems on the diagrams



Pain Keys:	
OOO	Pins & Needles
^^^	Burning
XXX	Aching
++++	Sharp or Stabbing
=====	Numbness & Tingling

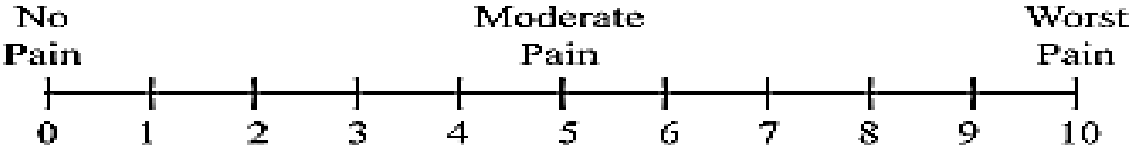
Please use the below space to describe your condition further if needed:

_____

_____

_____

Please use the diagrams below to indicate the intensity of pain
What is the level of pain at rest? _____
What is the level of pain with activity? _____
What aggravate your pain? _____
What decrease your pain? _____



No Pain	Minimal	Tolerate but hinder activity	50% of activities impaired	80% of activities impaired	Unbearable

_____ _____

Patient's Signature Therapist's Signature