Back-in-Action
REHABILITATION, S.C.

REHAB SERVICES MEDICAL HISTORY

Please answer the questions to the best of your ability. It may be necessary to observe certain precautions during your treatment if any of the following medical conditions exist. Thank you for your cooperation.

NAME: ______________________ DATE: ______________________

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

☐ high blood pressure	☐ cancer	☐ heart condition
☐ pacemaker	☐ diabetes	☐ circulation problems
☐ metal implants	☐ loss of sensation	☐ dizziness
☐ history of seizures	☐ currently pregnant	☐ stroke
☐ drug allergies (Please list) ______________________		

Do you smoke? YES NO

What is the condition that brought you to therapy? ______________________

____

Have you ever been treated before for this condition? ______________________

What is your goal for therapy? ______________________

List any medications you are currently taking ______________________

____

List any surgeries you have had ______________________

____

Please circle the number that best represents your pain (0=least, 10=most)

0 1 2 3 4 5 6 7 8 9 10

Circle the words that best describe your pain:

constant frequent occasional aching stabbing burning throbbing shooting

What makes your pain worse? ______________________

What makes your pain better? ______________________

______________________ Patient Signature

______________________ Therapist Signature