REHAB AT WORK
It's Our REHAB That WORKS
Via Web Site

PERSONAL HISTORY

How did your injury occur? _____

_____

Have you had any X-rays? _____ If yes, when? _____
Have you had any MRI's? _____ If yes, when? _____
Have you had any other tests? _____ If yes, type/s and when? _____

What type of treatment(s) have you had for this injury (please check)?

___ Acupuncture
___ Chiropractor
___ Epidural injections
___ Injections (cortisone, trigger point, etc.)
___ Physical Therapy
___ Other: _____

Have you had any surgery? _____ If yes, type/s and when? _____

What medications are you presently taking?

Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____

Please list any previous accidents/injuries/illnesses you have had: _____

_____

Do **YOU** have a history of the following (please check)?

Yes	No		Yes	No		Yes	No	
___	___	alcohol/drug use	___	___	head injury	___	___	respiratory problems
___	___	allergies	___	___	heart disease/pace maker	___	___	seizures
___	___	arthritis	___	___	high blood pressure	___	___	shortness of breath
___	___	cancer	___	___	injuries/surgeries	___	___	smoking
___	___	diabetes	___	___	mental illness	___	___	none reported
___	___	dizziness	___	___	osteoporosis	___	___	other: _____

If applicable, is there a chance you could be pregnant? _____

Do you have difficulty with any of the following (please check)?

___ automobile care
___ child care
___ dressing
___ driving
___ eating
___ grocery shopping
___ grooming
___ heavy cleaning
___ intercourse
___ laundry
___ leisure
___ light cleaning
___ meal preparation
___ public transportation
___ sports
___ vacuuming
___ yard work
___ none reported
___ other: _____

What is your main physical complaint? _____

_____

What, if anything, increases your pain? _____

_____

What, if anything, relieves your pain? _____

_____

_____ _____
Printed Name of Patient **Witness**