Atlantic Rehabilitation Center
Patient Medical History

Name:_____ Date:_____/_____/_____

Present/Past History: (Check if you ever had)

Arthritis/swollen joints		Gout	
Asthma, Bronchitis, or Emphysema		High Blood Pressure	
Angina, Coronary Heart Disease		Heart Attack or Surgery	
Anemia		Infectious Diseases (i.e. Active Tuberculosis)	
Bowel/Bladder Problems		Osteoporosis	
Breathing difficulties/Shortness of breath		Pacemaker	
Blood Clot/Emboli		Psychological/Emotional Problems	
Cancer or Chemotherapy/Radiation		Problems Sleeping	
Diabetes		Stroke/TIA	
Epilepsy/Seizures		Thyroid Problems	

Please check if you are taking any of the following medications:
Anti-inflammatory __ Muscle Relaxers __ Pain Medications __ Other __

List names of medications_____

Do you have any allergies? Yes__ No__ If yes, please list_____

Have you had any surgeries? Yes__ No__ If yes, please list_____

Do you smoke? Yes__ No__

Are you aware of your diagnosis? Yes__ No__

Are you pregnant? Yes__ No__

What is your main problem/complaint?_____

Estimated date of injury: _____/_____/_____

What are your goals/expectations for physical therapy?_____

Have you had any of the following medical or therapy services for this condition?

Physical Therapy__	Occupational Therapy__	Massage__	Chiropractor__
MRI__	X-Rays__	CT Scan__	EMG/NCV__
Neurologist__	Orthopedist__	General Practitioner__	Podiatrist__
Myelogram__	Other_____		

Are you currently working?
Full Time__ Part Time__ Modified Duty__ Not working__ Retired__

Is there an attorney involved in this case? Yes__ No__

Would you like to speak to a Social Worker or Vocational Rehabilitation Counselor? Yes__ No__

Date of next (referring) doctor's appointment:_____/_____/_____

Patient's Signature:_____ Date:_____/_____/_____