POST
RGV

OUTPATIENT REHABILITATION

PATIENT INFORMATION AND BRIEF MEDICAL HISTORY

Federal and State Regulations require a medical history must be included in the patient's medical record.

Patient Name:_____ Date:_____

DOB:_____ Reason For Therapy Referral:_____

Date of Onset of Injury/Condition:_____ Have you had previous therapy for this injury/condition?_____ Is this injury/condition work related? _____ If so, has it been reported to your employer? _____

Medical History:

Do you have currently or have you had in the past any of the following:

Diabetes	Yes	No	Sensitivity to heat	Yes	No
High Blood Pressure	Yes	No	Sensitivity to cold	Yes	No
Circulatory Disorders	Yes	No	Dizziness	Yes	No
Heart Disease	Yes	No	Seizures	Yes	No
Heart Attack	Yes	No	Headaches	Yes	No
Stroke/TIA	Yes	No	Cancer	Yes	No
Pacemaker	Yes	No	Visual Problems	Yes	No
Metal Implants	Yes	No	Allergies	Yes	No
Kidney Problems	Yes	No	Previous Surgeries	Yes	No
Hernia	Yes	No	Back Injuries	Yes	No
Nervous Disorders	Yes	No	Other injuries	Yes	No
Are you Pregnant?	Yes	No	Other Illnesses	Yes	No
Breathing Difficulties	Yes	No	Difficulty Sleeping	Yes	No
Osteoporosis	Yes	No	Neurological Problems	Yes	No
Weight Loss	Yes	No	DVT/Pulmonary Embolism	Yes	No
COVID-19	Yes	No	COVID-19 Vaccine	Yes	No

If you answered **YES** to any of the above, please explain and give appropriate dates:

_____

_____

_____

Medications:

Are you currently taking any medications? _____If **YES**, please let the medications, dosage and for what condition.

Medication Name *Dosage* *Condition*

_____

_____

_____

_____