## MEDICAL PROBLEMS: (please check only those that apply)

### CARDIOVASCULAR
- No Identified Problem
- Hypertension (High BP)
- Hypotension (Low BP)
- Heart Attack
- Chest Pain / Angina
- Irregular Rhythm or Murmurs
- Congestive Heart Failure
- Varicose Veins
- Pacemaker / Defibrillator
- Circulation Problems
- Pain in Calves with walking
- Blood Clots / Phlebitis
- Aneurysm
- Blood / Bleeding Disorder
- Other_________________________

### METABOLIC
- No Identified Problem
- Diabetes
  - Insulin Dependent
  - Oral Medications
  - Diet Controlled
- Blood Sugar
- Hyperthyroid
- Hypothyroid
- Other_________________________

### SOCIAL / PSYCHOLOGICAL
- No Identified Problem
- Alcohol Use ______ Times a Week
- Tobacco Use _____ Packs a Day
- Substance Abuse
- Depression
- Anxiety / Panic
- Claustrophobia
- ADD / ADHD
- History Abuse
- Under care of a Psychiatrist
- Under care of a Psychologist
- Other_________________________

### ORTHOPEDIC
- No Identified Problem
- Joint Replacements
- Type: _______________________
  - Type: _______________________
- Metal Implants / Internal Plate & Pins
- Osteoporosis / Osteopenia
- Amputation
- Fractures / Broken Bones
- Spinal Problems
- Osteoarthritis
- Sprain / Strain
- Other_________________________

### PULMONARY
- No Identified Problem
- Asthma / Bronchitis
- Emphysema / COPD
- Asbestos / Mesothelioma
- Shortness of Breath
- Tuberculosis (TB) / Exposure
- Pneumonia
- Snoring / Sleep Apnea
- Breathing Devices
- Dysphagia (Swallowing Problems)
- Other_________________________

### GASTROINTESTINAL
- No Identified Problem
- Hepatitis A B C
- Gastrointestinal Ulcers
- Hiatal Hernia
- Reflux
- Unexplained Weight Loss / Gain
- Anorexia / Bulimia
- Gall Bladder Disease
- Nausea / Vomiting
- Crohn’s Disease / Colitis
- Irritable Bowel Syndrome
- Diverticulitis
- Bowel Incontinence / Leakage
- Constipation
- Other_________________________

### NEUROLOGIC
- No Identified Problem
- Migraine
- Loss of Consciousness
- Balance Problems / Vertigo
- Fainting / Blackouts
- Parkinson’s Disease
- ALS (Lou Gehrig’s Disease)
- Rheumatic Fever
- Weakness in Arms or Legs
- Polio / Post-Polio Syndrome
- Epilepsy / Seizures
- Stroke (CVA) / TIA
- Head Injury / Concussion
- Memory Loss
- Confusion
- Spinal Cord Injury
- Level: _______________________
- Multiple Sclerosis (MS)
- Coordination Problems
- Dizziness
- Aphasia / Speech Problems
- Shunt Placement
- Hypoxia
- Other_________________________

### GENITOURINARY
- No Identified Problem
- Kidney Stones
- GYN Disorder
- Blood in Urine
- Kidney Disease / Failure
- Dialysis
- Urinary Bladder Burning / Urgency
- Freq
- Bladder Incontinence
- Leakage
- Prostate Disorder
- Other_________________________

### GENERAL MEDICAL
- No Identified Problem
- Glaucoma / Cataracts
- Vision Problems
- Glasses
- Hearing Deficit
- Hearing Aide(s)
- Blood Disease
- Anemia
- Cancer
- Type: _______________________
- Location: _______________________
- Chronic Pain
- Night Pain
- Skin Problems
- Edema / Swelling
- Lymphedema
- Rheumatoid Arthritis
- Infectious Disease
- Zoster / Shingles
- Chicken Pox
- Sexually Transmitted Disease
- Other_________________________

### PEDIATRIC / CHILDHOOD HEALTH HISTORY

#### Pediatric Patients ONLY
- No Identified Problem
- Intellectual Disability
- Down’s Syndrome
- Developmental Concerns
- Autism Spectrum
- Behavior Concerns
- Cerebral Palsy
- Birth Complications
- Chromosomal Abnormalities
- Other_________________________

### IMMUNIZATIONS

**List Actual Dates**
- DPT:
- Polio:
- MMR:
- TB:
- Chicken Pox:
- Hepatitis:
- HiB *(Bacterial Meningitis)*
CURRENT & RELEVANT Medical Problems / Conditions / Injuries NOT Listed Above  □ Not Applicable

CURRENT / PAST SURGICAL HISTORY  (Include Month / Year)  □ Not Applicable

CURRENT / PAST HOSPITALIZATIONS  (Include Month / Year)  □ Not Applicable

ALLERGIES
□ Seasonal  □ Latex  □ Tape / Adhesives  □ Perfume  □ Cold Intolerance
□ Other

WHAT IS THE REASON FOR YOUR THERAPY VISITS?
(List issues you experience with daily activities, mobility or communication)

Date of Onset  (Include Month / Year)  Date of Surgery  (Include Month / Year)

WHAT ARE YOUR REHAB GOALS?

FOR PEDIATRIC PATIENTS, What REHAB GOALS do you have for your CHILD?

Are you currently receiving or have you received any of the following services within the past year?
□ Physical Therapy  □ Occupational Therapy  □ Speech / Swallowing Therapy  □ Home Care

Current Height: _____’, _____”  Current Weight: _____ Pounds  Dietary Restrictions □ Yes □ No

Have you fallen in the last 6 months □ Yes □ No  How Many Falls? _________

Are you Pregnant? □ Yes □ No  Due Date:_______

Are there any religious or cultural practices that need to be considered in your care? □ Yes □ No Explain:

DIAGNOSTIC TESTS / IMAGING completed in this past year  (Include Body part & Month / Year)  □ Not Applicable

□ XRay  □ CT Scan  □ MRI  □ Other

□ Other

List ALL CURRENT MEDICATIONS  (Prescription & Non-prescription)  □ See Provided List  □ Not Applicable

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<th>Medication</th>
<th>Condition</th>
<th>Amount (Dosage)</th>
<th>How Often (Frequency)</th>
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List ALL CURRENT SUPPLEMENTS  (Nutritional Supplements, Vitamins, Herbal Remedies & Biomedical Treatments)  □ Not Applicable

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□ Patient □ Parent or □ Legal Guardian Signature ___________________________________________ Date___________

Therapist Signature ___________________________________________ Date___________