Arm and Hand Rehab
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Diamond Springs, CA 95619
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www.armandhandrehab.com

Medical History

Have you had therapy for this problem before? Yes No. If "yes", what type of treatment?_____

What diagnostic tests have been done? X-Ray___ MRI___ CT Scan___ Bone Scan___ EMG___ Myelogram_____

Which doctor ordered and reviewed the results?_____ Date last seen:_____

What medications are you currently taking?_____

Location of your pain and how are you managing it?_____

Pain Scale of 0 to 10 (0=No pain, 10=Unbearable pain)

Please mark you lowest level of pain and your highest level of pain

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

No Distress Take pain pill Unbearable/Agonizing

Allergies: Cortisone_____ Shellfish or Iodine _____ Other_____

Do you have any history of the following conditions? (Circle Yes or No for each item below)

Alzheimer's	Y N	Chest Pain	Y N	Hypoglycemia	Y N
Liver Disease	Y N	Hypertension	Y N	Seizures	Y N
Previous/Active Cancer	Y N	Diabetes	Y N	Stroke: (Date:_____)	Y N
Tuberculosis	Y N	Pacemaker	Y N	Anxiety Disorder	Y N
Lung Disease	Y N	Hepatitis	Y N	Drug/Substance Abuse	Y N
Hemophilla	Y N	Bruise Easily	Y N	Psychiatric Care	Y N
Arthritis	Y N	Hypotension	Y N	Circulatory Disorders	Y N
Cardiac Issues	Y N	Skin Disorder	Y N	Neurological Problems	Y N
Fractures	Y N	Immune System Disorder	Y N	Other:_____	Y N

What is your approximate body weight & height?_____ What is your average resting BP?_____

Have you ever had any other illness not noted above?_____ Any falls in last 3 months?_____ How many?_____

Have you ever had surgery?_____ When and what for?_____

Women only: Are you currently pregnant or trying to become pregnant?_____ How many months?_____

Are you currently breast feeding?_____ Smoker: Y/N How long:_____

The above information provided to my Therapist(s) is true to the best of my knowledge. If under 18 years of age, this must be signed by a parent or guardian, and they must be available during evaluation and treatment. I understand that it is my responsibility to inform the treating staff of any updates only medical status and convey concerns that I might have. I will inform the staff of any needs I have for accommodations. In order to maintain safe environment for the staff and the other patients, please call to reschedule if you have signs and symptoms (ie:fever) of cold/flu or other contagious illness.

Signature:_____ Date:_____ Reviewed By:_____