

Geer Rehabilitation

MEDICAL HISTORY

Please check if any of these conditions are applicable to you:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Low Back Pain/Neck Pain |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Lost pleasure in things you enjoy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Coordination problem | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Pain at night | <input type="checkbox"/> Cancer | <input type="checkbox"/> Parkinsons Disease |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Prolonged fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Peripheral neuropathy |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Developmental/growth problems | <input type="checkbox"/> Recent Repeated Infections |
| <input type="checkbox"/> Dizziness or blackouts | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Under Stress | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stomach problems/ulcers |
| <input type="checkbox"/> Feel down or hopeless | <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Fever/chills/sweats | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Weakness in arms or legs | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Weight loss | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Joint pain/swelling | <input type="checkbox"/> Headaches | <input type="checkbox"/> Infectious disease (eg TB, hepatitis) | |
| <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Do you have Pacemaker/Defibrillator? | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Do you use tobacco? |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Change in Balance/Falls |
| <input type="checkbox"/> Changes in Appetite | | | |

OTHER CONDITION/ILLNESS DIAGNOSED BY A PHYSICIAN: _____

PLEASE LIST ANY SURGERIES YOU HAVE HAD: _____

ARE YOU LATEX SENSITIVE? YES / NO

Are you currently taking any prescription medication? YES / NO Please list: _____

Are you currently taking any non-prescription medication? YES / NO Please list _____

Do you take any blood thinners (e.g. Coumadin, Plavix, etc.)? YES / NO

PAIN SCALE: Please indicate/mark the level of your pain, when it is at its least level and worst level:

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----
No pain at all As bad as it can be

Patient/Guardian Signature _____

Date: _____

FOR OFFICE USE ONLY: Reviewed and discussed by therapist: (PT initial) _____ Date: _____