Ruthe B. Cowl Rehabilitation Center

Patient History

Patient Name _____ DOB_____

What is the current problem for which you were referred? _____

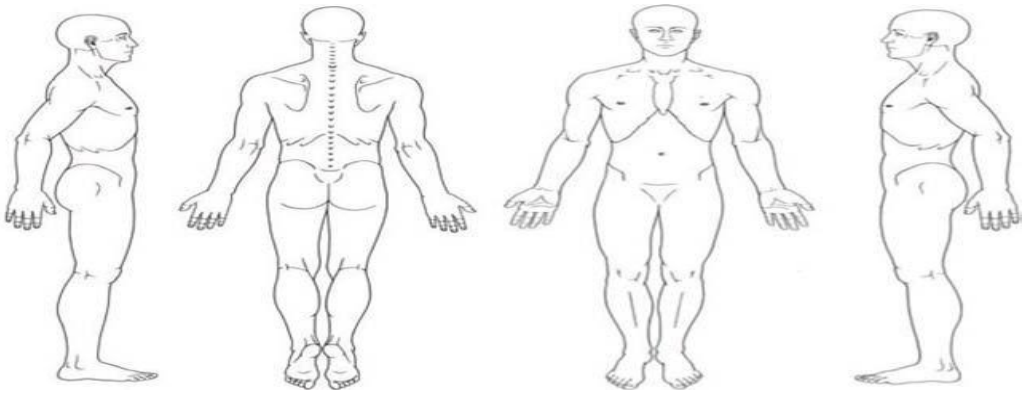
What is your current occupation?_____

Date of next doctor appointment:_____ When did your symptoms start?_____

How did your symptoms begin?_____

Please indicate on the body views, where you have pain and or other symptoms:

Please mark on body diagram with /// or xxx where each symptom is located: Pain ///
Pins & Needles xxx



Please rate your pain in this scale of 0-10.

0 1 2 3 4 5 6 7 8 9 10
no pain worst pain imaginable

Please list all medications you are presenting taking._____

_____

Please complete the following information regarding any special tests you have had done for this condition.

MRI X-ray CAT Scan other_____ Date completed_____

Have you had any of the following this year?

Physical Therapy __ Occupational Therapy __ Speech Therapy __ Chiropractic care __ Home care __

If yes, where were you treated and for what condition?

_____

Allergies (medications, environmental, tape, lotions, latex, food, other) _____

Past or Present Medical History

__ Cancer/Type _____
__ Metal Implants
__ Fractures
__ High Blood Pressure
__ Are you currently pregnant?
__ Smoke/how often _____
__ Arthritis
__ Headaches
__ Diabetes
__ Open Wounds
__ Cardiac Problems (describe below)
_____
__ Drink/how often_____
__ Stroke/When _____
__ Vision/Hearing Problems
__ History of HIV/Hepatitis
__ Pacemaker
__ Skin Problems
__ Asthma
__ Mental Illness

Other medical conditions or surgeries_____

_____

What goals do you hope to accomplish with your physical/occupational therapy? _____

_____

Patient's signature_____ Therapist's signature_____

Date _____ Date _____