Northfield Hospital + Clinics

Medical History – Rehabilitation Services

Your name: _____ Date: _____

Medical History

What is your primary physical complaint? _____

When and how did your injury or symptoms occur? _____

What activities are limited by this condition (e.g., lift, reach, grasp)? _____

_____

Are you currently pregnant? ❑ Yes ❑ No If yes: ❑ 1st trimester ❑ 2nd trimester ❑ 3rd trimester

What do you expect to accomplish with therapy? _____

What is your insurance company's name? _____

History of current injury/illness (pertinent to this current diagnosis): Please check those that apply

❑ Physical Therapy? .....When?.....❑ 0-1 years ago.....❑ 1-5 years ago.....❑ 5 years plus

❑ Occupational Therapy? .....When?.....❑ 0-1 years ago.....❑ 1-5 years ago..... ❑ 5 years plus

❑ Chiropractor?.....When?.....❑ 0-1 years ago.....❑ 1-5 years ago.....❑ 5 years plus

What was done? _____

❑ Injections: When? _____ Where? _____ Did it help? ❑ Yes ❑ No

❑ X-ray_____ ❑ MRI_____ ❑ CT scan _____

❑ Surgery: When? What kind? _____

Medications

❑ Blood thinner ❑ Muscle relaxants ❑ Sleeping aids
❑ High blood pressure ❑ Pain relievers ❑ Other: _____

Have you ever been diagnosed with any of the following?

	Yes	No		Yes	No		Yes	No
Tuberculosis			Cancer			Arthritis		
Diabetes			Hepatitis			Stroke		
Depression			Metal Implants			Osteoporosis		
Heart Condition			Epilepsy			Latex Allergy		
Hypertension			Respiratory Problems			Sulfa Allergy		
Pacemaker			Fibromyalgia					
Comments: _____								

Who is your employer? _____

Are you currently working? ❑ Yes ❑ No If "yes," the number of hours per week: _____
❑ Full Duty ❑ Restricted Duty

How many total work days have you missed? _____ Do you have a case manager / QRC? ❑ Yes ❑ No

Job requirements include: ❑ significant lifting ❑ significant walking
❑ extended periods of sitting ❑ extended periods of standing

Other job responsibilities not listed: _____

Therapist's signature_____ Date_____

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