AVALON REHAB

MEDICAL HISTORY

Patient Name: _____ **Age:** _____

Type of Injury / Condition: _____

Injury / Onset Date: _____

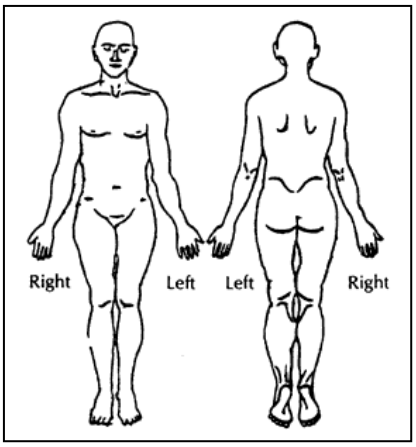
Type of Surgery and Date: _____

Next Doctor's Appointment: _____

Describe previous treatment for this condition: _____

Have you received physical therapy treatment this year? **Yes / No**

Have you received Home Health Care via Medicare this year? **Yes / No**



Have you had any imaging performed?

□ X-Ray □ CT Scan □ MRI □ Doppler □ Ultrasound

Have you recently noticed:

□ Weight Loss / Gain
□ Weakness
□ Pregnant / IUD
□ Pain at night
□ Nausea / Vomiting
□ Fever / Chills / Sweats
□ Headaches
□ Cramps in legs when walking
□ Fatigue
□ Numbness / Tingling
□ Change in Vision / Hearing
□ Insomnia

Do you have now or have you ever had any of the following:

□ Surgeries
□ Sprains / Strains
□ Heart Problems
□ Circulation Problems / Clots
□ Easy Bruising / Bleeding
□ Indigestion / Heartburn
□ Loss of Consciousness
□ Diabetes
□ Cancer
□ Asthma / Breathing Problems
□ Leg / Ankle Swelling
□ Fainting
□ Fractures
□ Blood Pressure Problems
□ Motor Vehicle Accident
□ Lung Disease
□ Urinary Problems / Infections
□ Allergies / Skin Sensitivity

□ Any previous injury that might affect current care _____

Explain and give approximate dates for any items given above _____

_____

Are you currently taking medications? **Yes / No**

Name or type of medications: _____

Type of pain: **Sharp** / Burning / Aching / Tingling / Numbness / Other _____

Rate your pain (1=minimal, 10=Severe):

At it's worst: 1 2 3 4 5 6 7 8 9 10 **At it's best:** 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment? _____

_____

What are your physical or fitness goals? _____

_____

Is there anything else you would like to include or ask your physical therapist? _____

_____

X _____

Signature - Patient or Representative Date