Foley Physical Rehab Patient History Form

Patient Name: _____ **Date**: _____

Medical History (Please Check if it applies)

Do you smoke? (If so how much?):_____

Caffeine drinks per day: _____
Alcohol use: _____
Mental Illness: _____
High Blood Pressure: _____
Heart Trouble: _____
Pace Maker: _____
Asthma: _____
Lung Disease: _____
Diabetes: _____
Arthritis (Type?): _____
Seizures: _____
Cancer (Where?): _____
Bleeding Disorder: _____
Drug Allergies/Latex Allergies: _____
Urinary Problems: _____
Pregnancy (How Far Along?): _____
How Many Pregnancy's Total? _____
C-Sections (How Many?): _____
Past or Present Victim of Abuse: _____

Surgeries (including joint replacements. Please list approximate Dates)

_____
_____
_____

Medications (Please list dosage and frequency):

_____
_____
_____

Other illnesses or injuries:

_____
_____
_____

Occupation:

_____

Present Symptoms

Where is your pain or problem located? _____
Describe your present pain: (__ sharp, __dull, __ache, _-increased pain @ night,_- numbness, __tingling,__ poor balance)_____
Please rate your pain from "0"=no pain to "10"=the worst pain you could imagine: (Circle One) now 0 1 2 3 4 5 6 7 8 9 10
At worst 0 1 2 3 4 5 6 7 8 9 10

Activities that make your pain WORSE:__ sitting BETTER:__sitting
__ standing __ standing
__ walking __ walking
__ lying down __ lying down

When did your present problem or flare-up start? (Approx. Date)_____
How did the injury occur? _____
How are you able to sleep? __No difficulty __Moderate Difficulty __Only with medication
Have you had any other tests for this condition? __X-Ray __MRI __CT scan Date of most recent test_____
Have you had prior treatment for this problem? (Approx. Date)_____
If so where, and was it successful?_____
Do you have frequent Headaches? How Often?_____
Do you exercise presently? (If so how often and what type?)_____
What is your present condition preventing you from doing that you would like to resume? _____