

# PAST MEDICAL HISTORY

Patient Name \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Are you presently working?  Yes  No Date of next doctor appointment \_\_\_\_\_

Date of injury/onset \_\_\_\_\_ Have you ever had these symptoms before?  Yes  No

Check which apply to your symptoms:

Work related injury  Recurrence of previous injury  Cause unknown  
 Motor vehicle injury  Injury related to lifting  Athletic/recreational injury

Have you had related surgery?  Yes  No

Do you have, or have you had any of the following?

	YES	NO		YES	NO
Diabetes	_____	_____	Allergies to aspirin	_____	_____
Chest pain/angina	_____	_____	Allergies to heat	_____	_____
High blood pressure	_____	_____	Allergy/intolerance to cold	_____	_____
Heart disease	_____	_____	Other allergies	_____	_____
Heart attack	_____	_____	Hernia	_____	_____
Heart palpitations	_____	_____	Seizures	_____	_____
Pacemaker	_____	_____	Metal implants	_____	_____
Headaches	_____	_____	Dizziness/fainting	_____	_____
Kidney problems	_____	_____	Recent fractures	_____	_____
Are you pregnant?	_____	_____	Surgeries	_____	_____
Cancer	_____	_____	Skin abnormalities	_____	_____
Bowel/bladder problems	_____	_____	Nausea/vomiting	_____	_____
Asthma/breathing difficulty	_____	_____	Ringling in your ears	_____	_____
Liver/gallbladder problems	_____	_____	Rheumatoid arthritis	_____	_____
Smoking	_____	_____	Special diet guidelines	_____	_____

If you marked "yes" on any of the above, please briefly explain and give an approximate date:

\_\_\_\_\_

\_\_\_\_\_

Is there any other information regarding your past medical history that we should know about?

\_\_\_\_\_

\_\_\_\_\_

Are you presently taking any medications?  YES  NO If yes, please list the medication and for what condition:

\_\_\_\_\_

\_\_\_\_\_

Do you participate in any sports, exercise programs or activities on a regular basis?  YES  NO

Rate the intensity of your pain on a scale of 1-10 (1 being no pain, 10 being the worst possible) \_\_\_\_\_

In the rare instance of an emergency, who should we contact?

Name \_\_\_\_\_ Phone number \_\_\_\_\_

I understand that the information I have provided is true and correct. With my signature below, I authorize treatment as recommended. I also authorize my insurance carrier to make any payment for services rendered to me or my dependents directly to the provider. I understand that I am fully responsible for any charges incurred for services rendered as well as costs incurred by Rehab Dynamics, LLC for collection on my account. I hereby authorize the release of all information relating to claims for benefits submitted on behalf of myself and/or my dependents.

Signature \_\_\_\_\_ Relationship to patient (if minor) \_\_\_\_\_