MAGNOLIA REGIONAL HEALTH CENTER
REHABILITATION SERVICES

Patient Name: _____ Date of Birth: _____ Date:_____

Please check all of the specific problems or conditions you have currently or previously had. Explain as needed.

Medical History

Condition/Disorder	*Type and/or Date*		*Type and/or Date*
☐ High Blood Pressure		☐ Cancer	
☐ Diabetes		☐ Asthma/Emphysema/COPD	
☐ Stroke		☐ Shortness of Breath	
☐ Head Injury		☐ Chest Pain	
☐ Migraines/Headaches		☐ Thyroid Disorder	
☐ Heart Disease		☐ Seizure Disorder	
☐ Pacemaker		☐ Anxiety/Depression	
☐ TMJ Disorder		☐ Broken Bones	
☐ GI (Stomach Issues)		☐ Arthritis	
☐ Vertigo/Dizziness		☐ Degenerative Joint Disease	
☐ Skin Disorder		☐ Degenerative Disc Disease	
☐ Reproductive Issues		☐ Osteoporosis/Osteopenia	
☐ Urinary Tract Infection		☐ Fibromyalgia	
☐ Kidney Disorder		☐ Other conditions	
☐ Hepatitis/HIV/AIDS		☐ Other conditions	
☐ Sexually Transmitted Disease		☐ Other conditions	

Allergies/Adverse Reactions

☐ Penicillin ☐ Sulfa drugs ☐ Latex Sensitivity or Allergy

☐ Other _____

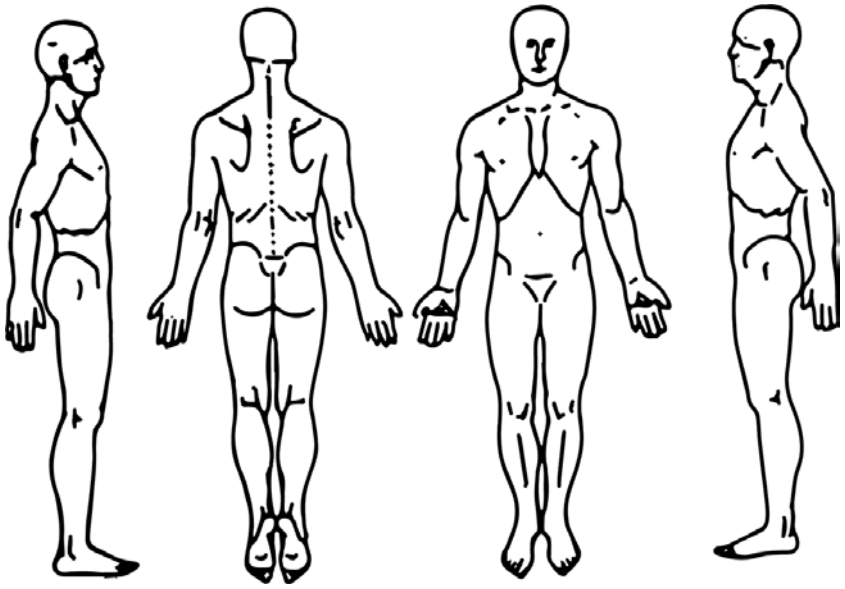
Surgical History

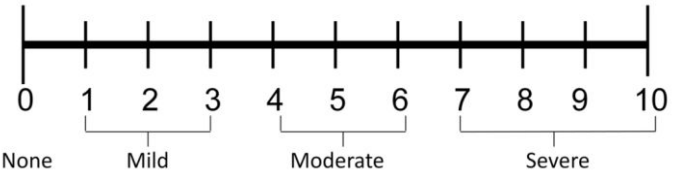
_____

_____

_____

On the following diagram please mark where you are hurting:





Rate your pain:

Now: _____

Best: _____

Worst: _____

What is the lowest pain number that you could live with: _____

Height: Weight: □Right handed □Left handed

How do you rate your health? □Good □Fair □Poor

When did your **current** symptoms begin? (If longer than 1 year ago, when did they worsen recently?)

How did your injury occur or symptoms begin (check all that apply)?
□Accident- Work related □Bending □Reaching □ Lifting
□Accident- Motor vehicle □Gradual onset □Falling □Other

Indicate daily activities you are having trouble with due to this injury or onset of symptoms (check all that apply).
□Sitting _____ minutes □Rising □Stairs □Reaching □ Other
□Standing _____ minutes □Turning □Lying □Housework □Athletics
□Walking _____ feet □Driving □Dressing □Grooming □Bending
□Sleeping _____ hours

What treatment and testing have you received for this condition (check all that apply)?
□Physical Therapy □ MRI □Injection □Bracing □Medication
□Occupational Therapy □X-Ray □Myelogram □ Orthotics □Chiropractic
□Nerve Conduction Study □CT Scan

If you had surgery for this condition, list the type of surgery _____ and the date of surgery _____.

Do you have any open cuts, lesions, or wounds? □Yes □No If yes, where:

Have you noticed a change in bowel or bladder frequency or control? □Yes □No
Do you experience bowel or bladder: □Leakage □Urgency □Frequency □Other

Have you fallen in the past year? □Yes □No If yes, how many times? _____
If yes to falling, did you sustain an injury as a result of the fall? □Yes □No

Do you experience frequent episodes of the following (check all that apply)?
□Headaches □Dizziness □Nausea □Ear Ringing □Balance Control

Do you wear glasses or contacts? □Yes □No
Do you have hearing difficulties? □Yes □No (If yes, do you wear a hearing aid? □Yes □No)
What is your preferred learning style? □Visual □Auditory □Demonstration □Any learning barriers?
Do you smoke? □Yes □No

Do you live alone? □Yes □No
If yes, do you have someone who can assist you in your recovery and care? □Yes □No
If no, who do you live with? □Spouse □Family □Significant Other □Other

Do you currently exercise, play sports, or have hobbies (if yes, please list)?

Current employment status? □Occupation _____ □Retired □Student □Disabled
Work activities mostly include: □Sitting □Standing □Walking □Lifting □Bending □Computer □Driving □Varied □Other:

What goals do you have for therapy? What do you hope you accomplish?

My next appointment with my doctor (who sent me here) is on _____/_____/_____ □No appointment scheduled

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Patient Medication List

Medications	Start Date	Reason for Taking	Dosage (mg, and times per day)