ARROW REHABILITATION
PHYSICAL • OCCUPATIONAL • SPEECH
OUTPATIENT THERAPY CENTER

MEDICAL HISTORY FORM

Name: ____________________________________ Occupation: _________________________

Present Illness or Injury:

What is your current problem? ____
How did the present injury occur? ____
Date of the injury? (Please be as accurate as possible): ______________________________
Did you undergo surgery? Yes ____ No ____ (If yes, when?): ___________________________
Have you had any testing? No ___ Yes ___/What type?:CT scan ___ MRI __ Xrays__ EMG ___
Have you had any previous therapy for this problem?: No ___ Yes ___ When? ______________
If you have any pain or discomfort, please describe below:
Location of pain _________________________ Intensity of pain (0-10,scale, 0= lowest): _____
(Circle one): Constant or Intermittent. What aggravates it? _____________________________
What helps it? ____
What can't you do with this condition? ____
List other symptoms associated with this condition:(Ex: weakness, numbness, less movement, etc)
____

MEDICAL HISTORY: * please checkmark if you have any of the following:

( ) diabetes
( ) heart disease
( ) high blood pressure
( ) hemophilia
( ) previous back problems
( ) shoulder dislocation
( ) metal implant
( ) allergies
( ) history of cancer
( ) respiratory illness
( ) kidney illness
( ) previous head trauma
( ) spinal injuries
( ) special diet restrictions
( ) currently pregnant
( ) surgery to head, neck or spine
( ) arthritis problems
( ) joint problems
( ) acute infections
( ) heart attack(s)
( ) stroke (s) (CVA) ___
( ) hernia
( ) pacemaker

List your current medications: ____
____

List any hospitalizations or surgeries in the past 5 years: ___________________________________
____

Have you had any previous physical, occupational or speech therapy in the last year?_________
If so, when and where:____

Have you had any home heath services in the last year?________If so, when and where:______
____

What are your expectations or goals while you are in therapy? __________________________
____

I have read and filled out this questionnaire to the best of my knowledge.

Patient Signature: ____________________________________ Date: ________________

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