VEREEN
REHABILITATION CENTER
SPORTS MEDICINE

Patient Information & Medical History Form

Date: _____

Name: _____ Birthdate: _____ Age: _____

Phone: _____ Email: _____

Bill To: □ Insurance □ Accident Liability □ Worker's Comp □ Self Pay □ Other: _____

Height: _____ Weight: _____ Referring Physician: _____ Primary Physician: _____

SOCIAL HISTORY: □ Single □ Married □ Divorced □ Widowed

Current Living Arrangements: □ Alone □ With Spouse □ With Other: _____

Children: □ No □ Yes, # _____ Grandchildren: □ No □ Yes, # _____

Use of Alcohol: □ No □ Yes Use of Tobacco: □ No □ Yes

Prior to Injury/Illness: □ Employed □ Retired □ Semi-Retired

Previous Functional Status: □ Independent □ Required Assistance: _____

Hobbies & Interests: (check all that apply)

□ sports □ fishing □ TV □ automobiles □ computer
□ cooking □ hunting □ movies □ music □ exercise
□ shopping □ gardening □ reading □ woodwork □ collector of: _____

Therapist's Comments: _____

MEDICAL HISTORY: (check all that apply)

□ heart disease □ diabetes □ high blood pressure □ pacemaker □ osteoporosis
□ cancer □ tuberculosis □ vision impaired □ epilepsy □ hepatitis
□ HIV/AIDS □ arthritis □ hearing impaired □ scoliosis □ pregnant
□ stroke □ asthma □ latex allergy □ fibromyalgia □ other

Therapist's Comments: _____

What durable medical equipment (DME) company do you use? _____

Where is your pain located? _____

What are your current symptoms? _____

When (***Please provide Date***) did the injury or problem occur? _____

First episode: _____ Second episode: _____ Third episode: _____

How did the injury or problem occur? _____

_____

Rate your pain using a 0-10 scale (0 = no pain, 10 = worst possible pain)

Worst Pain since Onset: _____ Least Pain since Onset: _____ Today's Pain: _____

What diagnostic test have you had for this problem?

□ X-ray □ MRI □ CT Scan □ Bone Scan □ EMG / NCV □ Other: _____

What medications are you currently taking for this problem? _____

List other medications: _____

Have you had any injections for this problem? □ No □ Yes; when? _____

Have you had surgery for this condition? □ No □ Yes; when? _____

List other surgeries: _____

What makes your pain/problem Better? _____

Worse? _____

Is there pain at night? □ No □ Yes In what position do you sleep best? _____

Is your pain: □ CONSTANT or □ INTERMITTANT

Is your pain satisfactorily controlled now? □ No □ Yes

Therapist's Comments: _____

_____

Are you exercising at home? □ No □ Yes; explain:_____

Are you using heat or cold? □ No □ Yes; explain: _____

Are you using a brace or sling? □ No □ Yes; explain: _____

When do you see a doctor for a follow-up appointment? _____

EMPLOYMENT HISTORY:

Are you currently working? □ No □ Returned □ Disabled □ Yes; where?_____

Are your work duties: □ Full □ Restricted Number of Days Missed: _____

What are your current duties or job description? _____

_____

What duties at work are restricted by your problem? _____

_____

FUNCTIONAL ASSESSMENT: Rate your abilities using the following scale.

Circle the number that best describes your ability for each area listed.

1 = Can do without difficulty 3 = Can do with great difficulty

2 = Can do with some difficulty 4 = Can't do at all

Lying down	1 2 3 4	Overhead reaching	1 2 3 4
Sitting	1 2 3 4	Driving a car	1 2 3 4
Standing	1 2 3 4	House work	1 2 3 4
Walking	1 2 3 4	Yard work	1 2 3 4
Jogging / Running	1 2 3 4	Self-Dressing / Hygiene	1 2 3 4
Going up stairs	1 2 3 4	Sexual activity	1 2 3 4
Going down stairs	1 2 3 4	Talking / Swallowing	1 2 3 4
Lifting / Carrying	1 2 3 4		

Therapist's Comments: _____

_____

How do you learn best? □ Demonstration □ Listening □ Video □ Reading

What are your desired outcomes with therapy? _____

_____

Therapist's Comments: _____

_____

To the best of my knowledge and belief, the information I have provided is complete and true. I herby give my consent to receive therapy services at Colquitt Regional Medical Center. I understand and agree with the treatment plan and goals that have been discussed with me.

Patient Signature: _____

Caregiver / Significant Other Signature: _____

Therapist Signature: _____