Apollo Rehab

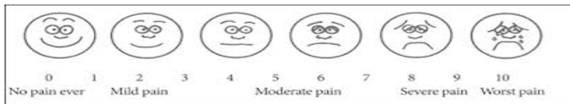
Patient Medical History

Name:_________________________________ Date:_____/_____/_____

Present/Past History: (Check if you ever had)

Arthritis/swollen joints		Gout	
Asthma, Bronchitis, or Emphysema		High Blood Pressure	
Angina, Coronary Heart Disease		Heart Attack or Surgery	
Anemia		Infectious Diseases (i.e. Active Tuberculosis)	
Bowel/Bladder Problems		Osteoporosis	
Breathing difficulties/Shortness of breath		Pacemaker	
Blood Clot/Emboli		Psychological/Emotional Problems	
Cancer or Chemotherapy/Radiation		Problems Sleeping	
Diabetes		Stroke/TIA	
Epilepsy/Seizures		Thyroid Problems	

Pain level:



Please check if you are taking any of the following medications:

Anti-inflammatory __ Muscle Relaxers __ Pain Medications __ Other __

List names of medications____

Do you have any allergies? Yes__ No__ If yes, please list______________________________

Have you had any surgeries? Yes__ No__ If yes, please list______________________________

Do you smoke? Yes__ No__

Are you aware of your diagnosis? Yes__ No__

Are you pregnant? Yes__ No__

What is your main problem/complaint?____

Estimated date of injury: _____/_____/_____

What are your goals/expectations for physical therapy?____

Have you had any of the following medical or therapy services for this condition?

Physical Therapy__ Occupational Therapy__ Massage__ Chiropractor__
MRI__ X-Rays__ CT Scan__ EMG/NCV__
Neurologist__ Orthopedist__ General Practitioner__ Podiatrist__
Myelogram__ Other____

Are you currently working?

Full Time__ Part Time__ Modified Duty__ Not working__ Retired__

Date of next (referring) doctor's appointment:_____/_____/_____

Patient's Signature:______________________________ Date:_____/_____/_____