SPOT Rehabilitation
Patient Health History

Patient's Name: _____ **Birthdate:** _____
Address: _____
Phone # (work): _____ **Cell** #: _____
Phone # (home): _____
Preferred method of contact (please circle one): home phone/cell/work/e-mail

E-Mail address: _____ ☐ **Appt. reminder**

Responsible Party if other than Patient:

Name: _____ Relationship _____
Phone # (work): _____ Cell #: _____
Phone # (home): _____

Emergency contact person(s):
Name: _____ Relationship: _____
Phone # (work): _____ Cell #: _____
Phone # (home): _____

Current Medications: _____
_____
Medications for Emergency use: _____

List known allergies: _____

Current Diagnoses: _____

Surgeries: _____

Has any imaging been Preformed (X-ray, MRI, CT Scan, etc.)?

Do you have any Developmental Milestones concern and what are they? _____
_____

What would you like us to help you or your child do? _____

Please check Current or past medical conditions:

___ Anemia
___ Ankle/Knee Injury
___ Arthritis
___ Asthma
___ Back Injury/Pain
___ Bleeding Disorder
___ Bone Fractures
___ Breathing Problems
___ Cancer
___ Chest Pain w/Exercise
___ Diabetes
___ Dizziness or Faintness
___ Elbow/Wrist Pain
___ Emphysema/Bronchitis
___ Epilepsy
___ Foot/Ankle Pain
___ Heart Disease/Problems
___ Head Injury/Concussion
___ High Blood Pressure
___ Infections
___ Joint Dislocations/Pain
___ Other _____
___ Knee/Hip Pain
___ Loss of Hearing
___ Migraine/Headaches
___ Neck Injury/Pain
___ Poor Circulation
___ Seizures
___ Swallowing Problems
___ Tendonitis
___ Vision Deficits/Blurred Vision

Signature: _____ **Date:** _____

How did you hear about us? Physician __ Family __ Friend __ Phone Book __ Other: _____

Reason for visit/pain area: _____ **When did symptoms start**: _____

Is your injury work or auto related: _____ **Work Duties:** _____

How and when did this problem start: _____

_____

Describe current symptoms: _____

Are symptoms since onset: ___ worse ___ better ___ same

How do you feel:

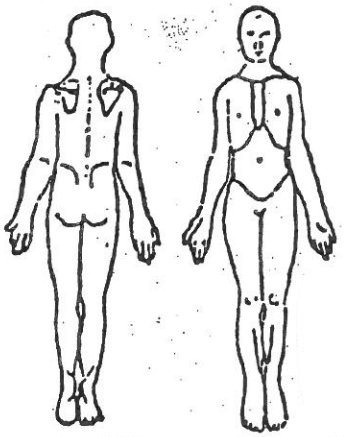
In the morning:	___ stiff	___ sore	___ fine	___ other: _____
Once you move around:	___ worse	___ better	___ same	
End of day:	___ worse	___ better	___ same	

Do you have pain at rest:_____ **Does it disturb your ability to sleep:** _____

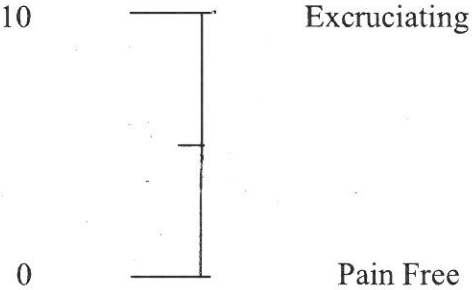
When are your symptoms for this problem the worse (please check all that apply):

___ overhead movements	___ reaching	___ grasping	___ bending
___ lying on your side	___ dressing	___ sitting	___ sit to stand
___ standing	___ walking	___ running	___ squatting
___ coughing/sneezing	___ driving	___ stairs	___ other _____

On the body chart, put X's on areas of pain and O's on areas of numbness/tingling



Pain Intensity (mark current, best and worst level)



Therapy goals: What would you like to be able to do that you cannot now (i.e.work, exercise…..) _____

Have you recently had:

___ Dizziness	___ loss of balance	___ significant night pain
___ fever	___ weight changes	___ bowel/bladder changes
___ sweats/chills	___ increased headaches	