# SPOT Rehabilitation and Home Health Care Patient Health History

**Patient's Name**: _____ **Birthdate:** _____
**Address:** _____
**Phone #** _____ work or home **Cell #:** _____
**Preferred method of contact (please circle one): home phone/cell/work/e-mail** ☐ **Appt. reminder**
**E-Mail address:** _____ **by E-Mail only**

**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: _____**