PALMETTO REHAB
PHYSICAL THERAPY

PAST MEDICAL HISTORY

Weight: _____ Height: _____ Date: ____ /____ /____

Please check if you have a history of or are currently having issues with any of the following:

☐ ADD/ADHD	☐ Dizziness	☐ Multiple sclerosis	☐ Pacemaker
☐ Allergies	☐ Epilepsy/ Seizures	☐ Headaches/Migraines	☐ Parkinson's Disease
☐ Asthma	☐ Gall Bladder Problems	☐ Hypertension (High BP)	☐ Psychiatric History
☐ Arthritis	☐ Gastrointestinal (ulcers)	☐ Hypotension (Low BP)	☐ Skin Disease
☐ Cancer	☐ Hepatitis, Jaundice	☐ Kidney/ Urinary	☐ Tuberculosis
☐ Diabetes	☐ Heart Disease	☐ Respiratory (Emphysema)	☐ Vascular Problems

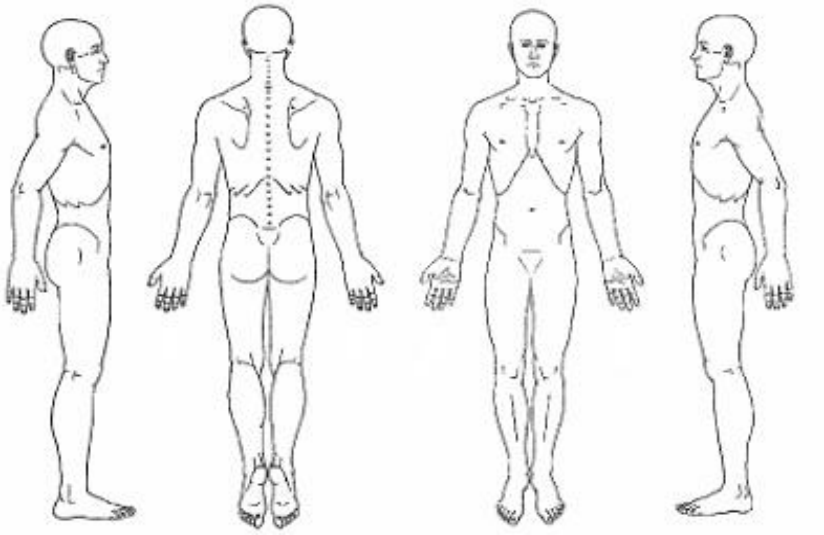
☐ Other Explain: _____

Are you a current smoker? ___ YES ___ NO If yes, would you like materials on smoking cessation? ___ YES ___ NO

BODY CHART

Please mark the location of your pain and the type of pain on the chart:

Key:	
X	Sharp stabbing pain
O	Dull achy pain
…	Numb/tingly pain
///	Throbbing
^^^	Burning



Pain Currently: no pain 0 1 2 3 4 5 6 7 8 9 10 Worst imaginable pain
Pain at Lowest: no pain 0 1 2 3 4 5 6 7 8 9 10 Worst imaginable pain
Pain at Worst: no pain 0 1 2 3 4 5 6 7 8 9 10 Worst imaginable pain

Have you fallen within the last year? ☐ YES ☐ NO

If yes, how many times? _____

Was an injury sustained during the fall? ☐ YES ☐ NO

What caused the fall(s)? _____
_____

Have you had any of the following services this year?

☐ Physical Therapy ☐ Occupational Therapy

☐ Chiropractic ☐ Home Health

Please list major surgeries/illnesses/hospitalizations with the last 10 years:

_____
_____
_____

Please list all current medications with dosages and reason for medication (attach separately if not enough space):

☐ *list attached separately*

_____
_____
_____

Patient Signature: _____ **Guarantor's Signature:** _____