

COPPELL SPINE & SPORTS REHAB L.P. MEDICAL HISTORY FORM

PATIENT NAME: _____ TODAY'S DATE: _____

REFERRING PHYSICIAN'S NAME: _____ DATE OF INJURY OR ONSET: _____

CAUSE OF INJURY OR ONSET: _____ ARE YOU PRESENTLY WORKING? Y N

PRIMARY CARE PHYSICIAN'S NAME: _____ DATE OF NEXT MD APPT: _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR
DO YOU USE TOBACCO? (circle one) YES NO IF YES, HOW MUCH? _____

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN _____ AND WHY _____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE / WHAT WERE THE RESULTS: _____

HAVE YOU HAD PRIOR PHYSICAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? _____

CURRENT MEDICATIONS: _____

ALLERGIES: Medication _____ Reaction _____ Medication _____ Reaction _____

ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction _____
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction _____

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DIABETES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> RESPIRATORY PROBLEMS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> ASTHMA <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> COPD <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> CARDIOVASCULAR PROBLEMS | <input type="checkbox"/> FRACTURES | <input type="checkbox"/> Other |
| <input type="checkbox"/> HOLTER MONITOR - currently wearing? | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> SEIZURES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> HEPATITIS/HIV | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> KIDNEY PROBLEMS | |
| <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> MRSA (Methicillin Resistant Staphylococcus Aureus) | |
| <input type="checkbox"/> CURRENTLY PREGNANT | <input type="checkbox"/> OSTEOPOROSIS | |

If checked any above, explain: _____

ANY OTHER MEDICAL PROBLEMS: _____

SIGNATURE OF PATIENT: _____ REVIEWED BY Therapist: _____ Date _____

Nutritional Questionnaire

Did you know your nutritional health can affect your recovery?

Are you currently taking any vitamins, minerals, nutritional supplements or herbal therapies? Please List:	Yes ___ No ___
Do you have any known sensitivities to vitamins, minerals or herbs? Please list:	Yes ___ No ___
Did you know many retail nutritional supplements MAY NOT have the potency, purity and consistency to provide you the most benefit?	Yes ___ No ___
Do you sometimes find yourself coping with fatigue, stress and a loss of energy?	Yes ___ No ___
Would you like to discuss a safe, effective energy enhancing formula, based upon a variety of herbs, vitamins and minerals designed to energize the organs without increasing blood pressure?	Yes ___ No ___
Have you suffered from joint pains and/or ailments? Would you like to speak with your therapist about a safe and effective alternative to assist with joint pain?	Yes ___ No ___
Would you be interested in talking about a safe and effective weight loss program based on appetite suppression and increased fat metabolism without stimulants?	Yes ___ No ___
A natural alternative to hormone replacement therapy, isoflavones are powerful antioxidants derived from soy. This support helps your body fight against the effects of aging. Have you heard about maintaining your hormonal balance naturally?	Yes ___ No ___
Did you know that your body absorbs vital minerals and vitamins more efficiently and strengthens your immune system while you sleep? Have you considered a safe sleep program based on calming herbs, mineral and vitamins that nourish your body while you rest?	Yes ___ No ___
Would you like to discuss the use of antioxidants?	Yes ___ No ___

Patient Name _____ Date _____

