Inspira Rehab Care □ Vineland Health Center □ Bridgeton □ Elmer □ Sports □ Tomlin Station

MEDICAL HISTORY / SUBJECTIVE INFORMATION

Name:_____ Date: ____/____/____ Birthdate: ____/____/____ Age: _____

Height: _____ Weight: _____ Referring Physician:_____

Medical History: (Please check all that apply)

____ Heart Disease	____ Diabetes	____ High Blood Pressure	____Pacemaker
____ Cancer	____ Tuberculosis	____ Visual Impaired	____ Epilepsy
____ HIV /AIDS	____ Arthritis	____ Hearing Impaired	____ Fibromyalgia
____ Stroke	____ Asthma	____ Latex Allergy	____ Scoliosis
____ Osteoporosis	____ Hepatitis	____ Pregnant	____ [Add]

_____

Therapist's comments: _____

_____

Have you had surgery for your condition? Y N

If yes, please give approximate date: _____

Have you had any injections for your condition? Y N

If yes, please give approximate date: _____

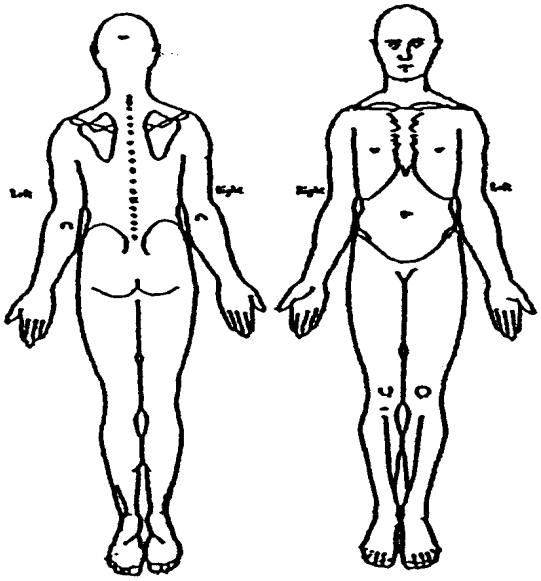
Please list any diagnostic tests you have had for this condition:

_____

How the injury or problem occur?_____

What are your current symptoms?

_____



When did the injury or symptoms occur? First episode:_____Second episode:_____Third episode:_____

Please rate your pain using a 0 – 10 scale (0 = no pain, 10 = the worst pain you can imagine)

Worst pain since onset:_____ **Best** pain since onset:_____**Today's** pain:_____

Where is your pain or problem located? _____

Is your pain? Constant Intermittent

What makes your pain / problem **better**?_____**Worse**?_____

Is there pain present at night? Y N

What position helps you to sleep? _____

Previous Level of Function: _____

Therapist's Comments:_____

_____

Please complete the back page >

Employment History:

Are you currently working? Y N If no, how many total days of work have you missed?_____

Are your work duties? Full Restricted How many hours per week do you work?_____

Who is your employer?_____

What type of work do you do?_____

What critical work duties have been most affected by your problem?_____

What do you hope to accomplish with therapy?_____

_____

PLEASE RATE YOUR ABILITIES USING THE FOLLOWING SCALE:

1 = CAN DO WITHOUT DIFFICULTY **3 = CAN DO WITH GREAT DIFFICULTY**

2 = CAN DO WITH SOME DIFFICULTY **4 = CAN'T DO AT ALL**

					Comments: **Therapist use only**
Lying down	1	2	3	4	
Sitting	1	2	3	4	_____
Standing	1	2	3	4	
Walking	1	2	3	4	_____
Jogging/running	1	2	3	4	
Going up stairs	1	2	3	4	_____
Going down stairs	1	2	3	4	
Lifting/carrying	1	2	3	4	_____
Driving a car	1	2	3	4	
Overhead reaching	1	2	3	4	_____
Housework	1	2	3	4	
Yardwork	1	2	3	4	_____
Dressing	***1***	***2***	***3***	***4***	
Sexual activity	1	2	3	4	_____

Do you smoke? Y N If yes, how much?_____

What type of non-work activities/hobbies are you involved in?_____

When are you scheduled to see you doctor again? _____

Vital Signs: BP: _____ HR: _____ RR: _____

Therapist's comments:_____

_____

_____

_____

Therapist Signature:_____

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services at Inspira Rehab Care. I also acknowledge that I have received a copy of the patient bill of rights.

Patient Signature:_____ Date: _____