ECHN REHABILITATION SERVICES – MEDICAL HISTORY

☐ **Rockville Hospital** ☐ **Manchester Hospital** ☐ **Glastonbury** ☐ **South Windsor** ☐ **Ellington**

PLEASE COMPLETE THIS FORM SO THAT WE MAY PROVIDE YOU WITH SAFE, EFFECTIVE TREATMENT.

Patient Name	Date of Birth	Date of Next MD Appointment
Referring Provider	Primary Care Provider (if different)	Date Problem Started
Hand Dominance: ☐ Right ☐ Left	Height:	Weight:

MEDICAL/SURGICAL HISTORY:

Are you presently taking any medications (prescription and/or non-prescription) ? ☐ Yes ☐ No If yes, please list them

_____

_____

☐ **SEE ATTACHED MEDICATION LIST**

Have you ever been hospitalized or had surgery? ☐ Yes ☐ No
If yes, please describe and give dates: _____

Have you had any recent falls (last 6 months)? ☐ Yes ☐ No

PLEASE PUT AN "X" NEXT TO ANY OF THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST:

	Arthritis (e.g. rheumatoid/ osteoarthritis)		High Blood Sugar/Diabetes		Muscular Dystrophy
	Osteoporosis/Osteopenia		Low Blood Sugar/Hypoglycemia		Parkinson's Disease
	Broken Bones/Fractures		Lung/Breathing Problems (e.g. Asthma/ Emphysema/ COPD)		Multiple Sclerosis
	Fibromyalgia		Thyroid Problems		Seizures/Epilepsy
	Lupus		Kidney Problems		Head Injury
	Circulation/Vascular Problems		Ulcers/Stomach Problems		Vision/Hearing Problems
	Heart Problems (e.g. angina/congestive heart failure/MI)		Blood Disorders		Depression/Anxiety
	Pacemaker		Infectious Disease (e.g. TB, HIV/AIDS, hepatitis)		Allergies (If yes, please list below)
	Stroke		Cancer		Latex Allergy/Sensitivity
	High Blood Pressure		Developmental/Growth problems		Pregnancy

Other pertinent medical information, including allergies noted above, as well as any additional information regarding your medical history or injury that you would like to share with us:

_____

_____

_____

_____

_____

Patient Name: _____ DOB: _____

CURRENT CONDITION(S)/CHIEF COMPLAINT(S):

What problem(s) are you experiencing (*check all that apply)?*

- ☐ Pain – Location: _____
- ☐ Problem with walking
- ☐ Loss of motion in my joints
- ☐ Unable to work, play, or go to school
- ☐ Problem with breathing
- ☐ Unable to play sports or do leisure activities
- ☐ Weakness – Location: _____
- ☐ Problem with balance
- ☐ Unable to take care of myself
- ☐ Unable to do household chores
- ☐ Problem with endurance
- ☐ Other _____

When did the problem(s) begin (date)? Month _____ Year _____

What happened? _____

_____

Have you ever had this problem(s) before? ☐ Yes ☐ No Did the problem get better? ☐ Yes ☐ No
If yes, did you receive physical or occupational therapy for this problem? ☐ Yes ☐ No

Are you seeing anyone else for the problem(s)? ☐ Acupuncturist ☐ Chiropractor ☐ Massage Therapist
☐ Other _____

Do you currently receive Home Health Services? ☐ Yes ☐ No If yes, what company? _____

PAIN ASSESSMENT:

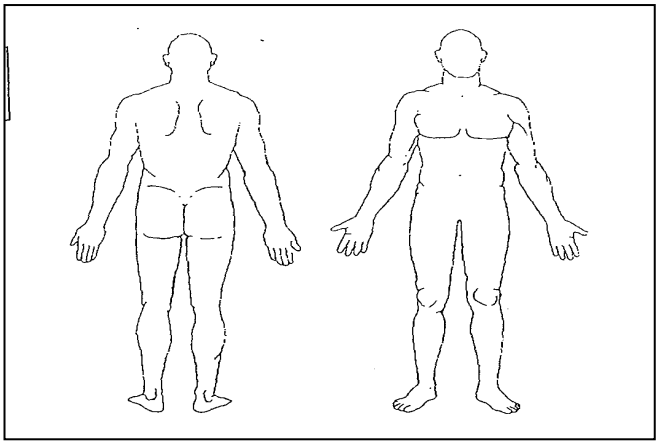
How would you rate your pain on a daily basis? ***(None)*** 0 1 2 3 4 5 6 7 8 9 10 ***(Worst)***

Does the pain increase with ☐Coughing ☐Swallowing ☐Breathing ☐Sneezing

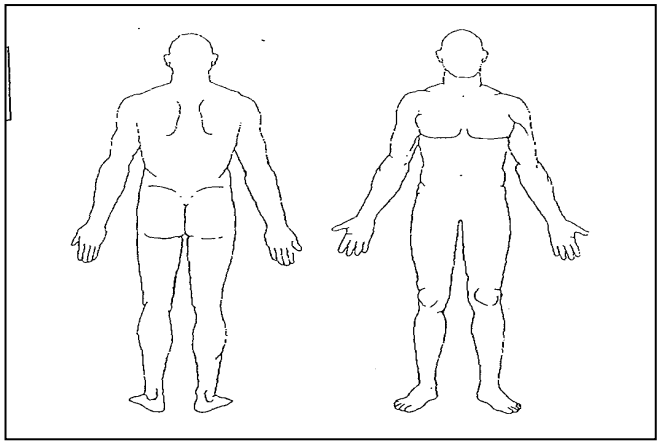
What do you do to make your pain better? _____

What makes your pain worse? _____

SHADE IN AREAS OF PAIN



SHADE IN AREAS OF NUMBNESS, TINGLING, BURNING



GENERAL HEALTH STATUS:

Please rate your overall health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How many hours do you sleep? _____ Position? _____ Is your sleep restful? ☐ Yes ☐ No

Have you had major life changes during past year? (e.g. new baby, job change, death of a family member):

☐ Yes ☐ No

Patient Name: _____ DOB: _____

LIVING ENVIRONMENT:

Type of Housing?

☐ House ☐ Apartment/Condominium ☐ Group Home ☐ Assisted Living
☐ Other: _____

With whom do you live?

☐ Alone ☐ Spouse/Significant Other ☐ Spouse/Significant Other & Others
☐ Child (not spouse/sign. other) ☐ Other Relatives ☐ Group Setting
☐ Personal Care Attendant ☐ Other _____

Does your home have:

☐ Stairs, no railing* ☐ Stairs, w/railing* ☐ Ramps ☐ Elevator ☐ Uneven Terrain
☐ Assistive Devices (e.g. Bathroom) _____ ☐ Any obstacles: _____

***If your home has stairs, how many *into* the home?** _____ ***Inside* the home?** _____

EMPLOYMENT/WORK HISTORY:

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Homemaker ☐ Student ☐ Retired ☐ Unemployed
Are you presently working? ☐ Yes ☐ No If no, how long have you been out of work? _____
Is your present injury work related? ☐ Yes ☐ No Occupation: _____
Is Lifting required as part of your job? ☐ Yes ☐ No Lifting Restrictions: _____

SOCIAL/HEALTH HABITS:

Smoking: Do you smoke? ☐ Yes ☐ No Packs per day _____ # Years? _____
Alcohol: Do you drink alcohol? ☐ Yes ☐ No How many days/week? _____ Drinks per day? _____
Exercise: Do you exercise beyond normal daily activities and chores? ☐ Yes ☐ No
If yes, describe the exercise and how many days per week you exercise? _____

LEARNING STYLE:

What is the easiest way for you to learn? ☐ Reading ☐ Listening ☐ Pictures ☐ Demonstration
Do you have any barriers to learning? ☐ None ☐ Language ☐ Hearing ☐ Vision ☐ Other
Primary Language: _____

_____ _____
Patient or Authorized Representative Signature **Date**

_____ _____
Signature of Therapist who reviewed with patient **Date**

STATE STATUTES REQUIRE THE CONFIDENTIALITY OF THIS INFORMATION.
A COPY OF THIS MATERIAL SHALL NOT BE TRANSMITTED TO ANYONE WITHOUT WRITTEN CONSENT OF THE PATIENT.