Morton Hospital
A STEWARD FAMILY HOSPITAL
Steward

Rehabilitation Services Department
Northwoods Medical Center
2005 Bay Street Taunton, MA 02780
Phone: (508) 828-7265 • Fax: (508) 828-7264

Name:_____
MR#:_____

Medical History

Date of Birth: _____ Age: _____ Height:_____ Weight:_____
Job Title:_____ Employer:_____

Current Problem you are seeking therapy for?:_____
_____
When did the injury occur?_____
How did the injury occur?_____
Diagnostic tests done (X-ray, MRI, etc.)? Yes No If yes, what?_____
List the activities that are difficult for you because of your injury:_____
_____
_____

Please circle your current pain level: 0 1 2 3 4 5 6 7 8 9 10 (0=no pain, 10=worst pain)
Acceptable pain level: 0 1 2 3 4 5 6 7 8 9 10 (What level of pain can you function with?)

(* Indicate potential for falls risk)
Have you ever been diagnosed with any of the following: (please circle all that apply)

CARDIOVASULAR:

High Blood Pressure	Y	N
Low Blood Pressure*	Y	N
Heart Attack	Y	N
Stroke*	Y	N
Bleeding Disorder	Y	N
Congestive Heart Failure	Y	N

Other (please specify)
_____

NEUROLOGICAL:

Vertigo*	Y	N
Seizures*	Y	N
Ataxia	Y	N
Parkinson's*	Y	N
Numbness/Tingling*	Y	N

If yes, where:_____

Balance issues *	Y	N
Dizziness*	Y	N
Fainting*	Y	N

Other (please specify)
_____

PULMONARY:

Tuberculosis	Y	N
COPD	Y	N
Asthma	Y	N
Chronic Bronchitis	Y	N
Emphysema	Y	N

Other (please specify)
_____

SYSTEMIC:

Diabetes	Y	N
Cancer	Y	N
Rheumatoid Arthritis	Y	N
Hernia	Y	N
Hepatitis	Y	N

Other (please specify)
_____

MUSCULOSKELETAL:

Osteoporosis	Y	N
Osteoarthritis	Y	N
Degenerative Joint Disease	Y	N
Fibromyalgia	Y	N

Other (please specify)
_____

Name:_____
MR#:_____

Do you have uncorrected vision or hearing problems?* Y N
Do you use glasses?* Y N Do you use hearing aids?* Y N
Have you fallen in the last 6 months?* Y N
Do you use an assistive device for ambulation (i.e. crutches, cane, walker)?* Y N
Any history of surgeries? Y N If yes, what/when_____
_____

Medication*: (please list any and all medications you are currently taking. This includes vitamins and supplements)

MEDS/OTCs/HERBALS	DOSAGE	FREQ	DATE

Please List Any Allergies:

Personal Goal you wish to achieve with therapy:_____
_____

Please circle your preferred learning style: Verbal Written Demonstration

_____ _____
Person completing this form PT/OT reviewing this form

_____ _____
Relationship to the Patient Date/Time