To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. All information is considered confidential and will be released only to your physician unless prior written authorization is given. Thank you.

NAME: ______________________________ OCCUPATION: ______________________

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Are you currently seeing any of the following for your current condition? (Check box)

- ☐ Physician (M.D., D.O.)
- ☐ Psychiatrist/Psychologist
- ☐ Attorney
- ☐ Dentist
- ☐ Physical Therapist
- ☐ Chiropractor

Have you EVER been diagnosed as having any of the following conditions?

☐ Cancer, If YES, describe what kind:____________________

☐ Heart Problems	☐ Rheumatoid Arthritis	☐ Prostate Problems	☐ Anemia
☐ Pacemaker	☐ Other Arthritic Conditions	☐ Epilepsy/Seizure Disorders	☐ Ulcers
☐ Circulation Problems	☐ Osteoporosis	☐ Depression	☐ Liver Disease
☐ High Blood Pressure	☐ Kidney Disease	☐ Sexual Transmitted Diseases	☐ Tuberculosis
☐ Lung Disease	☐ Thyroid Problems	☐ Fibromyalgia	☐ Allergies
☐ Asthma	☐ Stroke	☐ Chemical Dependency (i.e. alcoholism)	☐ Latex Allergy
☐ Diabetes			☐ Other:_________

Please list any surgeries or other conditions for which you have been hospitalized for within the last few years, including the approximate date of the surgery or hospitalization:

DATE	SURGERY/HOSPITALIZATION	DATE	SURGERY/HOSPITALIZATION
________	______________________	________	______________________
________	______________________	________	______________________

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains) within the last few years and the approximate date of injury:

DATE	INJURY	DATE	INJURY
________	______________________	________	______________________
________	______________________	________	______________________

Have you recently noted:

☐ Weight loss/gain	☐ Nausea/vomiting	☐ Weakness	☐ Numbness/tingling
☐ Fatigue	☐ Dizziness	☐ Shortness of breath	☐ Headaches
☐ Fever/chills/sweats	☐ Pain at night	☐ Difficulty swallowing	☐ Change of appetite

Have you fallen within the past 12 months? Yes No

During the past month, have you often been bothered by feeling down, depressed, or hopeless? Yes No

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes No

How much coffee or caffeine containing beverages do you drink per day? ________

How many packs of cigarettes do you smoke a day? ________

If one drink equals one beer or glass of wine, how much alcohol do you drink in a week? ________

How are you able to sleep at night? ☐ Fine ☐ Moderate difficulty ☐ Only with medications

OVER

On the scales below, please circle the number which best represents the average level of pain you have experienced over the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

1. ____

2. ____

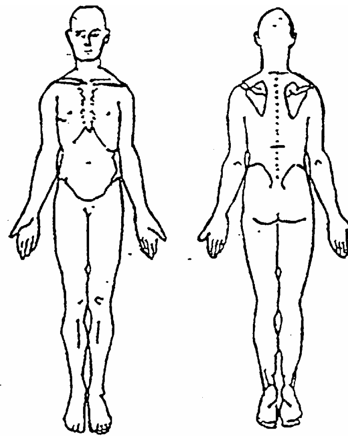
3. ____

Below for the Therapist:
Rating:________
Rating:________
Rating:________
AVG:_________

Therapist Use

Unable to Perform Activity	0	1	2	3	4	5	6	7	8	9	10	Able to perform activity at same level as before your (injury or problem)

Body Chart: Please mark your present symptoms on the Body Chart.



Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or skin patches):

____

____

Which of the following OVER-THE-COUNTER medications have you taken in the last week? (Check the box.)

- ☐ Aspirin
- ☐ Tylenol
- ☐ Decongestants
- ☐ Laxatives
- ☐ Antacids
- ☐ Antihistamines
- ☐ Vitamins/mineral supplements
- ☐ Advil/Motrin/Ibuprofen
- ☐ Other

Have you been seen by a home health agency within the last 60 days? _________ yes ___________ no

How did you hear about Northern Rehab?

- ☐ Physician
- ☐ Yellow pages
- ☐ Family/Friend
- ☐ Website
- ☐ Newspaper
- ☐ Drive-by

Therapist Use

Form reviewed with patient? YES ☐ NO ☐

______________________________ ______________________________.

Date Therapist signature