Austin Rehab of Union
Medical History Sheet

Name_____ Date_____
Referring Doctor's Name_____
Date injury/pain started ___/___/_____
How did it start? _____
Have you received treatment for this condition in the past? Y/N
Which type? _____
Where is your pain? _____
Describe your symptoms_____
_____

Is your pain: getting better getting worse staying the same
Are you currently being seen by a **Home Health Agency**? Yes /No
Rate your pain from 0-10: where 0 is no pain and 10 is Emergency Room pain (Circle #)

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 - 8 – 9 – 10

Medications: (Use back of sheet for more if needed, or give us copy of medications list to copy)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Personal Health History:

___ Diabetes	___ Seizures	___ High Blood Pressure	___Stroke/CVA
___Dizziness	___Blood Clots	___ Stomach Ulcers	___Nausea
___Asthma	___COPD	___Emphysema	___Short of breath
___History of cancer. Type: _____		___Any Implants_____	
___Pacemaker	___Arthritis	___ Vision Problems	___Difficulty hearing

Are you currently pregnant or think you may possibly be pregnant? Yes / No
Allergies: _____
Past surgeries: _____
Are you a smoker? Yes / No ___Blood disease_____
Any other medical history we should be aware of for your/our safety or treatment considerations? Y/N

Employment:
Employer_____ Job Title_____
Are you currently working? Y/N F/T P/T Regular Duty Light Duty Date last worked__/__/___

Anyone under 18 years of age must be accompanied by a parent or guardian for the initial evaluation and subsequently at any scheduled treatment unless approved by the treating therapist.

I authorize that all of the preceding information is correct about my medical history and I consent to my treatment and plan of care and/or the treatment of my minor child.

_____ _____ _____
Patient/ Guardian Signature Relationship to Patient (if necessary) Date