



West Rehab Services

Physical, Speech, & Occupational Therapy, Sports Medicine, Wellness

MEDICAL HISTORY & PHYSICAL CONDITION INFORMATION

Savannah 7135 Hodgson Mem Dr Savannah, GA 31406 (912) 353-WEST (912) 353-9232 fax	Hinesville 512 South Main Street Hinesville, GA 31313 (912) 368-4131 (912) 368-4132 fax	Richmond Hill 2709 US Highway 17, 2A Richmond Hill GA 31324 (912) 756-5699 (912) 756-5388 fax	Rincon 804 Towne Park Drive Rincon, GA 31326 (912) 826-5450 (912) 826-6413 fax	Pooler 1000 Towne Center Blvd Pooler, GA 31322 (912) 330-0155 (912) 330-0153 fax	Pembroke 205 East Bacon Street Pembroke, GA 31321 (912) 653-0040 (912) 653-0038 fax	Wilmington Island 107 Charlotte Rd, Ste. D Wilmington Is, GA 31410 (912) 897-1114 (912) 897-6114 fax	Skidaway Island 11 West Cross Road Savannah, GA 31411 (912) 598-8557 (912) 598-2569 fax
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Answers to the following questions will assist the therapist in providing a safe and effective treatment program.

Name: _____ Age: _____ Occupation: _____

Referring Physician: _____ Primary Care Physician: _____

Problems to be treated: _____

Next appointment with referring physician: ____/____/____ Date of Onset of Illness or Injury: ____/____/____

Have you ever had Physical/Occupational Therapy before? YES NO

Have you had treatment for this problem before? YES NO

If YES, state where and treatment given: _____

Have you had surgery associated with this problem? YES NO

If YES, please list date and type of surgery: _____

Are you currently taking any medications? YES NO

If YES, please list all medications: _____

Do you now have/or have you at any time had any of the following?

- | | | |
|---|--|--|
| High Blood Pressure <input type="radio"/> YES <input type="radio"/> NO | Diabetes <input type="radio"/> YES <input type="radio"/> NO | Dizzy/Lightheadedness <input type="radio"/> YES <input type="radio"/> NO |
| Heart Disease/Attack <input type="radio"/> YES <input type="radio"/> NO | GERD (reflux disease) <input type="radio"/> YES <input type="radio"/> NO | Headaches <input type="radio"/> YES <input type="radio"/> NO |
| Pacemaker <input type="radio"/> YES <input type="radio"/> NO | Sensitivity to Heat/Ice <input type="radio"/> YES <input type="radio"/> NO | Stroke <input type="radio"/> YES <input type="radio"/> NO |
| Cancer <input type="radio"/> YES <input type="radio"/> NO | Circulation Problems <input type="radio"/> YES <input type="radio"/> NO | Multiple Sclerosis <input type="radio"/> YES <input type="radio"/> NO |
| Metal Implants <input type="radio"/> YES <input type="radio"/> NO | Thyroid Problems <input type="radio"/> YES <input type="radio"/> NO | Seizures <input type="radio"/> YES <input type="radio"/> NO |
| Arthritis <input type="radio"/> YES <input type="radio"/> NO | Kidney Problems <input type="radio"/> YES <input type="radio"/> NO | Depression/Anxiety <input type="radio"/> YES <input type="radio"/> NO |
| Fibromyalgia <input type="radio"/> YES <input type="radio"/> NO | Allergies <input type="radio"/> YES <input type="radio"/> NO | Other Nervous Disorders <input type="radio"/> YES <input type="radio"/> NO |
| Balance Problems <input type="radio"/> YES <input type="radio"/> NO | Asthma <input type="radio"/> YES <input type="radio"/> NO | HIV/AIDS <input type="radio"/> YES <input type="radio"/> NO |
| Hearing Problems <input type="radio"/> YES <input type="radio"/> NO | Emphysema/Bronchitis <input type="radio"/> YES <input type="radio"/> NO | Hepatitis <input type="radio"/> YES <input type="radio"/> NO |
| Vision Problems <input type="radio"/> YES <input type="radio"/> NO | Tuberculosis <input type="radio"/> YES <input type="radio"/> NO | Anemia <input type="radio"/> YES <input type="radio"/> NO |

Are you currently pregnant? YES NO

If YES on any of the above, please explain and give approximate dates: _____

Please list any additional major illnesses or surgeries: _____

Do you need assistance with any of the following?

- | | | |
|---|---|--|
| Transportation <input type="radio"/> YES <input type="radio"/> NO | Shopping/Errands <input type="radio"/> YES <input type="radio"/> NO | Domestic Chores <input type="radio"/> YES <input type="radio"/> NO |
| Meals <input type="radio"/> YES <input type="radio"/> NO | Personal Care <input type="radio"/> YES <input type="radio"/> NO | Other _____ |

Has your illness/disability caused any of the following?

- | | | |
|---|---|--|
| Financial Problems <input type="radio"/> YES <input type="radio"/> NO | Emotional Problems <input type="radio"/> YES <input type="radio"/> NO | Family Problems <input type="radio"/> YES <input type="radio"/> NO |
| Other _____ | | |

Is there anything else we should know? _____

The above information is correct to the best of my knowledge.

Signature: _____ Date: _____