

SOCIAL & MEDICAL HISTORY

Patient's Name: _____

Social History

Language: English spoken/understood; Other language you speak most often

Education: Highest grade completed (circle one): 9, 10, 11, 12, college graduate, advanced degree

With whom do you live?

alone spouse only spouse and other(s) child only
 other relative(s) group setting personal attendant other

Employment/Work/School?

employed full time employed part time retired homemaker
 student

Occupation: _____

Cultural/Religious: Do you have any customs or religious beliefs or wishes that might affect therapy?

Living Environment

Does your home have:

Stairs Y N Railings Y N Ramps/Inclines Y N Uneven Terrain Y N Grab bars in shower Y N

General Health Status

Please rate your overall health:

Excellent Good Fair Poor

Have you had any major life changes during the past year? Yes No
(eg, new baby, job change, death of a family member)

Exercise

Do you exercise currently beyond normal daily activities and chores? No Yes; If so, describe the exercise _____; on average how many days/hours per week do you exercise? _____

Medical/Surgical History

Please check if you have ever had:

<input type="checkbox"/> Asthma, Bronchitis, or Emphysema	<input type="checkbox"/> Severe or frequent headaches	<input type="checkbox"/> Knee injury/surgery
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<input type="checkbox"/> Shortness of breath/chest pain	<input type="checkbox"/> Vision difficulties or disease	<input type="checkbox"/> Foot injury/surgery
<input type="checkbox"/> Coronary heart disease or Angina	<input type="checkbox"/> Hearing loss or tinnitus	<input type="checkbox"/> Thyroid trouble/goiter
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Dizziness or fainting	<input type="checkbox"/> Anemia
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Numbness or tingling	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Heart attack or heart surgery	<input type="checkbox"/> General weakness	<input type="checkbox"/> Gout
<input type="checkbox"/> Stroke/ TIA	<input type="checkbox"/> Weight loss/energy loss	<input type="checkbox"/> Sleeping problems
<input type="checkbox"/> Blood clot/ Emboli	<input type="checkbox"/> Arthritis/swollen joints	<input type="checkbox"/> Emotional problems
<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Pins or metal implants	<input type="checkbox"/> Bowel or bladder problems
<input type="checkbox"/> Other neurological disorder	<input type="checkbox"/> Joint replacement	<input type="checkbox"/> Reflux disorder
<input type="checkbox"/> Infectious disease	<input type="checkbox"/> Neck injury/surgery	<input type="checkbox"/> Pregnant at this time
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Back injury/surgery	<input type="checkbox"/> Currently smoke
<input type="checkbox"/> Cancer or chemotherapy/radiation	<input type="checkbox"/> Shoulder injury/surgery	<input type="checkbox"/> Allergies
<input type="checkbox"/> Hernia		<input type="checkbox"/> Other

Have you had any of the following medical or rehabilitation services for the injury/illness for which you are being seen?

<input type="checkbox"/> ENG/ Caloric tests	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Platform Posturography (balance test)	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> EMG/NCV	<input type="checkbox"/> Massage Therapy
<input type="checkbox"/> MRI	<input type="checkbox"/> Chiropractor
<input type="checkbox"/> CT Scan	<input type="checkbox"/> Neurologist
<input type="checkbox"/> X-Rays	<input type="checkbox"/> ENT specialist
<input type="checkbox"/> Other tests	<input type="checkbox"/> Other specialist/care

Please provide any additional relevant medical or surgical history:

Medication History

What prescription or non-prescription drugs are you currently taking? (please list or provide a current copy)

Are you aware of what your diagnosis is? Yes No

WHAT ARE YOUR EXPECTATIONS/GOALS RELATED TO THE REASON YOU ARE RECEIVING THERAPY?