Confidential Medical History

Lawrence Rehabilitation The Gait Center

Name: _____ Date of Birth: _____/_____/_____

Chief Complaint:_____

Date of Injury/Onset of Symptoms: _____/_____/_____ Date of Surgery: _____/____/_____

Referring MD: _____

Primary Care Physician: _____

Have you had any Rehabilitation or Diagnostic Services for this injury?

□Therapy □MRI □X-rays □Other_____

Is your condition related to:

□ Auto Accident

□ Other Accident

□ Work Related

Employer:_____

List all medications you are currently taking: (or provide office with copy of list) _____

_____

Are you allergic to any medication or latex?_____

List any surgeries and year: _____

_____

Do you have (or have you had in the past) any of the following conditions? Please check all that apply.

☐ Anemia	☐ A Pacemaker	☐ Allergies
☐ Back Pain	☐ Angina/Chest Pain	☐ Asthma
☐ Bronchitis	☐ Blood clot/Emboli	☐ Bowel/Bladder problems
☐ Drink Alcohol	☐ Coronary Heart Disease	☐ Dizziness or Faintness
☐ Gout	☐ Emphysema	☐ Epilepsy/Seizures
☐ Hernia	☐ Hearing Difficulties	☐ Heart Attack
☐ Parkinson's	☐ High Blood Pressure	☐ Kidney Disease
☐ Severe/Frequent Headaches	☐ Pneumonia	☐ Pregnant
☐ Stroke/TA	☐ Sleeping Problems	☐ Smoke Cigarettes
☐ Vision Difficulties	☐ Thyroid Problem	☐ Varicose Veins
☐ Women's Health Issues	☐ Weakness	☐ Weight Loss/Energy Loss
☐ Joint Replacement	☐ Arthritis	☐ Cancer
☐ Pins or metal Implants	☐ Numbness or Tingling	☐ Diabetes Type: 1____ 2 ____
☐ Osteoporosis	☐ Other _____	☐ Other _____

What part(s) of your body prompted today's visit? (Please specify left, right or both)

_____

_____

_____

Have you fallen in the last 12 months? ____ Yes ____ No

If yes, were you injured? _____

How many days per week do you exercise? _____

Recreation/Sports/Hobbies: _____

HEIGHT: _____ **WEIGHT:** _____

_____

_____

BMI: (completed by office) _____

Patient/Parent/Guardian Signature: _____ **Today's Date:** _____/_____/_____