Confidential Medical History

The Gait Center
LAWRENCE REHABILITATION

Name: (as written on insurance card) _____

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:** _____ _____

Patient/Parent/Guardian Signature: _____ **Date:** _____/_____/_____