Appling HealthCare System
Appling Rehabilitation Services
MEDICAL HISTORY/ SUBJECTIVE INFORMATION

Name:_____ Date:____/____/____ Birthdate:___/___/___ Age:_____

Height:_____ Weight:_____ Referring Physician:_____

Medical History: (Please check all that apply)

___ Heart Disease	___ Diabetes	___ High Blood Pressure	___ Pacemaker
___ Cancer	___ Tuberculosis	___ Visual Impaired	___ Epilepsy
___ HIV/AIDS	___ Arthritis	___ Hearing Impaired	___ Fibromyalgia
___ Stroke	___ Hepatitis	___ Laytex Allergy	___ Scoliosis
___ Osteoporosis	___ Asthma	___ Pregnant	___ [Add]

Therapist's Comment's:_____
_____

Have you had surgery for your condition? Y N If yes, give approximate date:_____

Have you had any injections for your condition? Y N If yes, give approximate date:_____

Please list any diagnostic tests you have had for this condition:_____

Please list any medications that you are taking?_____

_____

Do you have any known allergies to food/medications? (Please List)

_____

What are your Current symptoms?

_____

When did the injury or symptoms occur?
First episode:_____ Second episode:_____ Third Episode:_____
How did this injury or problem occur?

_____

Please rate your pain using a 0-10 scale (0= no pain, 10= the worst pain you can imagine)

Worst pain since onset:_____ Best pain since onset:_____ Todays pain_____
Where is your pain or problem located?_____
Is your pain? Constant Intermittent

What makes your pain/problem better?_____ Worse?_____

Is there pain present at night? Y N What position helps you to sleep?_____

Therapist's Comments:_____
_____

Would you like to speak to someone regarding abuse or neglect that you have recently experienced? Y N

Employment History:

Are you currently working? Y N If no, how many total days of work have you missed?_____

Are your work duties? Full Restricted How many hours per week do you work?_____

Who is your employer?_____

What type of work do you do?_____

What critical work duties have been most affected by your problem?_____

What do you hope to accomplish with therapy?_____

_____

Please complete this following page

Please rate your abilities using the following scale:

1= CAN DO WITHOUT DIFFICULTY
2= CAN DO WITH SOME DIFFICULTY
3= CAN DO WITH GREAT DIFFICULTY
4= CAN'T DO AT ALL

					Comments: Therapists use only
Lying down	1	2	3	4	
Sitting	1	2	3	4	_____
Standing	1	2	3	4	
Walking	1	2	3	4	_____
Jogging/Running	1	2	3	4	
Going up stairs	1	2	3	4	_____
Going down stairs	1	2	3	4	
Lifting/Carrying	1	2	3	4	_____
Driving a Car	1	2	3	4	
Overhead reaching	1	2	3	4	_____
Housework	1	2	3	4	
Yard work	1	2	3	4	_____
Dressing	1	2	3	4	
Sexual Activity	1	2	3	4	_____

Are you exercising at home? Y N If yes, what type?

Are you using heat or cold? Y N If yes, what type?

Are you wearing a sling or brace? Y N If yes, what type?

Do you smoke? Y N If yes, how much?

What type of non-work activities are you involved in?_____

When are you scheduled to see your doctor again?_____

Therapist's Comments:_____
_____
_____

Therapist Signature:_____

To the best of my knowledge and belief, the information I have given is complete and true. I hearby give my consent to receive therapy services at Appling Healthcare System.

Patient Signature:_____