CAPE REGIONAL
Physical Therapy

Patient Medical History

Name:	Referring Physician
Family Physician:	Date of first doctor visit for this injury
Last date worked due to injury	Date returned to work after this injury

	Yes	No
Is an Attorney Involved in this case?		
Have you had Surgery for this injury?		
Type of Surgery		
Number of Surgeries 1 2 3 4		
Took place in: Hospital Or Surgery Center		

Are you currently taking any prescription or nonprescription medication , If so Please list all Medication

Have you had any of the following Medical or Rehabilitative Service for this injury /Episode? _____

	Yes	No		Yes	No
Chiropractor			Ct Scan		
Emg/NCV			General Practitioner		
Massage Therapy			MRI		
Myelogram			Neurologist		
Occupation Therapy			Orthopedist		
Physical Therapy			Podiatrist		
Emergency Room Care			X-Rays		
Other					

Do you now have or have you ever had Any of the following?

	Yes	No		Yes	No
Asthma, Bronchitis or Emphysema			Severe or Frequent Headaches		
Shortness of Breath / Chest Pain			Vision or Hearing Difficulties		
Coronary Heart Disease or Angina			Numbness or Tingling		
Pacemaker/Defibrillator			Weakness		
High Blood Pressure			Weight Loss/Energy Loss		
Heart Attack			Hernia		
Stroke/TIA			Varicose Veins		
Blood Clot/Emboli			Allergies		
Epilepsy/Seizures			Any Pins or Metal Implants		
Thyroid Trouble/Goiter			Joint Replacement		
Anemia			Neck Injury/Surgery		
Infectious Disease			Shoulder Injury/Surgery		
Diabetes			Elbow Injury/ Surgery		
Cancer or Chemotherapy			Back Injury/Surgery		
Arthritis/Swollen Joints			Knee Injury /Surgery		
Osteoporosis			Leg/Ankle/Foot Injury/Surgery		
Gout			Dizziness or Fainting		
Sleeping Problems/Difficulties			Are you Pregnant?		
Emotional/Psychological Problems			Do you smoke?		
Bowel or Bladder Problems					

List Any other information that would assist you in your care _____

	Yes	No
Are you aware of what your diagnosis is?		

Based upon your awareness, What are your expectations/goals while in this program?