BACKGROUND INFORMATION & MEDICAL HISTORY FORM

EXCEL REHABILITATION & SPORTS THERAPY

To ensure you receive a complete and thorough evaluation, please provide us with information regarding your health status found on this form. If you do not understand a question, leave the area blank and your therapist will assist you.

Name:_____Date:_____

Are you currently: ____Working at your usual job with no restrictions. ____Working at your job with restrictions.
____Unable to work because of your condition since:_____ Unable to work due to other medical reasons.
____ Retired/Unemployed/Homemaker.

Have you ever had physical therapy for this condition? Circle: YES / NO

Are you currently seeing:

____Medical Doctor ____Dentist ____Psychiatrist/Psychologist ____Osteopath ____Physical Therapist
____Chiropractor

If you have seen any of the above during the last three months, please describe reason (illness, medical conditions, injury, routine physical etc.)

Have you EVER been diagnosed as having any of the following conditions?

YES NO Heart Problems	YES NO hearing Loss/Disorder	YES NO Circulation Problems
YES NO High Blood Pressure	YES NO Eye Disease	YES NO Osteoporosis
YES NO Stroke	YES NO Muscle Disease/Disorder	YES NO Cancer
YES NO Rheumatoid Arthritis	YES NO Multiple Sclerosis	If yes, what kind:_____
YES NO Other Arthritic Problem	YES NO Diabetes	YES NO Past Pregnancy
YES NO Epilepsy	YES NO Tuberculosis	Delivery: Vaginal Caesarian
YES NO Lung Disease	YES NO Hepatitis	YES NO Currently Pregnant? ____months
YES NO Emphysema/Bronchitis	YES NO Kidney Disease	YES NO Other:_____
YES NO Asthma	YES NO Thyroid Problems	YES NO Latex Allergy
YES NO Chemical Dependency	YES NO Depression	YES NO Skin Infections (MRSA/ Ringworm)

Please List any surgeries or other conditions for which you have been hospitalized, including dates and reasons.

Date: Surgery: Reason

Please describe any injuries for which you have been treated (fractures, dislocations, sprains/strains).

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for the following?

YES NO Diabetes	YES NO Epilepsy	YES NO Cancer
YES NO Heart Disease	YES NO Chemical Dependency	YES NO Headaches
YES NO High Blood Pressure	YES NO Tuberculosis	YES NO Mental Illness

Which of the following OVER- THE- COUNTER medications have you taken in the past week?

YES NO Aspirin	YES NO Decongestants	YES NO Antihistamines
YES NO Advil/Motrin/Ibuprofen	YES NO Antacids	YES NO Vitamins/Mineral Supplements
YES NO Tylenol	YES NO Laxatives	

List all PRESCRIPTION Medications you are currently taking (pills, injections, and skin patches):

Medicine Allergies:_____

How Much Caffeine per day?_____Cigarettes smoked per day?_____Days a week you drink alcohol?_____

Have you recently noted:

YES NO Weight Loss/Gain	YES NO Nausea	YES NO Fatigue
YES NO Weakness	YES NO Fever/ Chills/ Sweats	YES NO Numbness or Tingling

Form Reviewed with patient: YES NO Therapists Signature_____Date:_____