Medical History Form



		Case In	<u>formation</u>		
Evaluation Date:			Height:	Weight:	
Name:			Date of Birth:		
Home Address:			G	ender: M / F	
Home Phone:			Mobile Phone:		
Email Address:					
	RehabPain ManagementStrengtheningMobility / Walking ce TrainingSurgical RehabOther: ately when did your symptoms begin?				
					?
	NoYe	s: Work Injury	Yes: Motor Vehicle A	ccident	
Reason for Therapy	y:				
Injury Rehab	Pain Mana	gementStren	gtheningMob	ility / Walking	
Balance Traini	ngSurgical Re	habOther			
Approximately who	en did vour sympton	ns begin?			
How did you becor	u become injured / Did something specific happen to bring on your symptoms?				
Which parts of you	r body are affected?	Check all that app	ly:		
Head	Neck	Midba	ck / Chest / Ribs	Low Back	/Pelvis
Shoulder	Arm	Elbow/	/Forearm	Wrist/Har	nd
Нір	Knee	Ankle/	Foot	Other:	
Please list the med	ical care you have re	eceived for this inju	ry to date (Check all th	at apply):	
Medical Evalua	tion Spe	cialist Evaluation	Physical Ther	apy Chiroprac	tic
Radiographs (X	-Ray)MR	I / CT Scan / EMG	Injections	Nerve Ab	lation
Surgery	Me	dications (Fill out c	hart below or provide n	nedication list)	
Baxter 14884 Kirkwood Drive Baxter, MN 56425 P: 218.824.5027 F: 218.824.8011	Crosslake 35544 Sandpoint Drive Suite A Crosslake, MN 56442 P: 218.692.5020 F: 218.692.5021	Pierz 26814 143rd Street Pierz, MN 56364 P: 320.468.0183 F: 320.468.2075	Inver Grove Heights 5836 Blaine Avenue Suite 105 IGH, MN 55076 P: 651.455.0535 F: 651.455.1565	Pine River 409 Barclay Avenue PO BOX 785 Pine River, MN 56474 P: 218.587.5022 F: 855.367.2851	Takedown 17192 State Hwy 371 Brainerd, MN 56401 P: 218.824.5027 F: 218.821.8011

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Medicati	on	Dose	Method of Admir	Method of Administration (i.e. Oral)	
What type of symptor	ns are you experiencing	g?			
Pain			Weakness		
Limited Motion	Poor Balance	Trouble Walking	Difficulty completing da	aily activities	
Please rate the severi	ty of your pain on a sca	le from 0 to 10 (0 = no pain :	10 = worst pain possible):		
Today:/10	At best over last 48 ho	ours: <u>/10</u> At worst o	over last 48 hours: <u>/10</u>		
What types of activitie	es / motions / positions	are you having trouble wit	h?		
Activities:	Moti	ons:	Positions:		
Medical History:					
AIDS/HIV	Asthma	Cancer	Allergies (Circle): N Environmental / Of		
Bowel	Bladder	Chemical	Circulatory/	Depression /	
Problems	Problems	Dependency	Vascular Problems	Anxiety	
Epilepsy	Diabetes (Circle): Type I / Type I		Heart Trouble	Hepatitis	
High Blood Pressure	Stroke	Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	
Kidney Problems	Thyroid Problem	sAnemia / Blood Disorders	Metal implants and with a battery (Pa	l/or medical devices cemaker)	

Functionally speaking, what types of activities would you like to be able to do without being affected by your symptoms or related difficulties?

Baxter	Crosslake	Pierz	Inver Grove Heights	Pine River	Takedown
14884 Kirkwood Drive	35544 Sandpoint	26814 143rd Street	5836 Blaine Avenue	409 Barclay Avenue	17192 State Hwy
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