Rehab Professionals of Cleveland, Inc.

PATIENT HISTORY

Name _____ Age _____ Occupation _____

Do you have any metal implants? Yes No Do you have a pacemaker or defibrillator? Yes No

Please circle if you have ever been **diagnosed** as having any of the following conditions?

Heart Problems	Anemia	Asthma	Circulation problems
High Blood Pressure	Hepatitis	Cancer	Chemical Dependency
Kidney Disease	Depression	Arthritis	Emphysema/Bronchitis
Multiple Sclerosis	Diabetes	Stroke	Epilepsy
Thyroid Problem	Fractures	Tuberculosis	

List all Prescription and Over the Counter Medications, Vitamins and Supplements

Medication Name	Dose	Times per day	Route(pill, drop, injection)	Medication Name	Dose	Times per day	Route(pill, drop, injection)

List Hospitalizations or Surgeries with dates:_____

_____

_____

In general, would you say your health is: Excellent Very Good Good Fair Poor

Have you: Suffered an injury from a fall in the last year? Yes No
Fallen two or more times in the past year ? Yes No

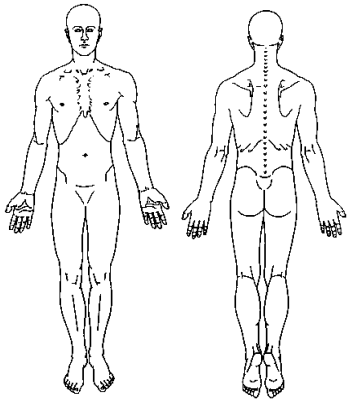
How many caffeinated beverages do you drink in a typical day? _____
How many packs of cigarettes do you smoke a day? _____
How long have you had this injury or condition? _____

I have had recent:

Weight gain/loss	Yes	No
Nausea	Yes	No
Dizziness	Yes	No
Fatigue	Yes	No
Fever/chills/sweats	Yes	No

Please rate your level of Pain
0= No Pain 10= Worst you can imagine

At your best 0 1 2 3 4 5 6 7 8 9 10
At your worst 0 1 2 3 4 5 6 7 8 9 10



Please mark area of current symptoms