First Coast REHABILITATION
where patient care comes first

MEDICAL HISTORY

PATIENT NAME:	AGE:	DATE:

Height:_____ Weight:_____ Refused ☐

How did you hear about First Coast Rehabilitation?_____

Have you previously received services from First Coast Rehabilitation? ☐ Yes ☐ No

Have you ever, or are you presently being treated for any of the following problems?
PLEASE CHECK THE APPROPRIATE BOX.

Heart Trouble	Yes ☐	No ☐	Emphysema	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Back Injury	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Headaches	Yes ☐	No ☐	Bleeding Disorder	Yes ☐	No ☐
Dizziness	Yes ☐	No ☐	Fracture	Yes ☐	No ☐
Fainting Spells	Yes ☐	No ☐	Cancer	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Pacemaker	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	Metalology (implants)	Yes ☐	No ☐
Pregnancy	Yes ☐	No ☐	Respiratory Problems	Yes ☐	No ☐
Seizures	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Allergies	Yes ☐	No ☐
Pelvic Pain	Yes ☐	No ☐	Other		
If so, what?					

Date of injury: _____ How did the injury occur: _____

_____

Work related or recreational activities you participate in regularly _____

Have you been hospitalized for the present problem? Yes ☐ No ☐ If so, when? _____

Have you had surgery for the present problem? Yes ☐ No ☐ If so, when? _____

Have you received Home Health in the past 30 days? Yes ☐ No ☐ If so, when? _____

Have you received previous treatment for this problem? Yes ☐ No ☐ If so, when? _____

If yes, please summarize the results: _____

_____

Is there currently any other health, medical, or chiropractic services being rendered to you by any other agency, organization or individual, including home health? Yes ☐ No ☐

If yes, please explain: _____

_____

Last seen by Physician (Date): _____ Next appointment with Physician: _____

Are you on any medications? Yes ☐ No ☐ Complete Medication form

Have you ever had any of the following (check all that apply):

☐ EMG ☐ CAT SCAN ☐ MYELOGRAM ☐ X-RAY ☐ MRI

Have you ever received Physical Therapy, Occupational Therapy, or Speech Therapy services elsewhere?

Yes ☐ No ☐ If yes, where, when, and why: _____

_____

I believe the above to be true and correct to the best of my knowledge.

Patient Signature: _____ Date: _____