Medical History Summary List

Name:_____ Age:_____ Date:____/____/____

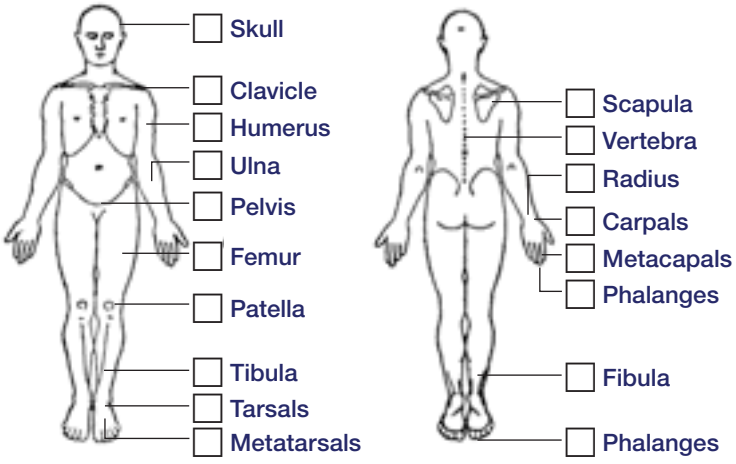
Medical History

(Please Check If Yes)

- ☐ Heart Disease
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Stroke / TIAs
- ☐ Cancer
- ☐ Parkinson's
- ☐ Arthritis
- ☐ Scoliosis
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ HIV /AIDS
- ☐ Falls
- ☐ Reflux
- ☐ Hearing Impaired
- ☐ Visually Impaired
- ☐ Pregnant

Allergies (check all that apply):

- ☐ Latex (rubber glove material)
- ☐ Avocado ☐ Banana
- ☐ Kiwi ☐ Tomato
- ☐ Other:_____



Please check the location pictured above and state the current symptoms or problems below. (i.e. pain, numbness, weakness)

Symptoms:_____

Other Medical History:

_____

Surgical History (include dates):

_____

Current Medications:

_____

Currently receiving any home health services?

☐ No ☐ Yes

If yes, what services?

_____

To the best of my knowledge and belief the information I have given is complete and true. I hearby give my consent to receive therapy services at Warm Springs Rehabilitation Centers.

_____

Patient Signature

_____

Therapist Signature

Date_____ Time_____