Medical History

Your Name:_________________________________ Date of Birth: _______________
Diagnosis: _________________________________ Date of Injury: _______________
Date of Surgery (if applicable): ___________________

Please list significant past injuries or surgeries relevant to the condition for which you are seeking treatment:
Type ____Year _________________
Type ____Year _________________
Type ____Year _________________

Please check the appropriate box if you have had any of the following:

- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Lyme Disease
- ☐ Pacemaker
- ☐ Skin Diseases/Abnormalities
- ☐ Stroke
- ☐ Asthma/Difficulty Breathing
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Dizziness/Fainting
- ☐ Nausea/Vomiting
- ☐ Heart Disease
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Psychiatric Disorders
- ☐ Bowel/Bladder Abnormalities
- ☐ Hepatitis
- ☐ Immune Deficiency/AIDS

If Female, are you pregnant? ☐ Yes ☐ No

- ☐ Other _____________________________

Have you recently experienced:

- ☐ Depression/Anxiety
- ☐ Difficulty Sleeping
- ☐ Decreased Activity Levels
- ☐ Numbness/Tingling
- ☐ Edema
- ☐ Headaches
- ☐ Night Pain
- ☐ Other ____________________________

Please list any allergies you have: ____

Please list medications you are currently taking and the reason for the medication:
____
____

Please remember to note any drugs you take for pain or lymphedema.

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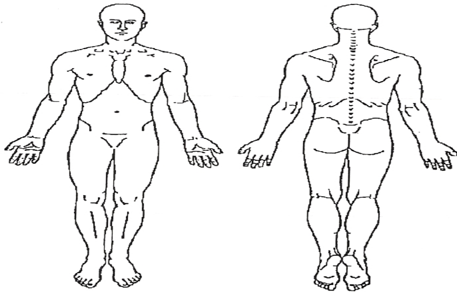
Please indicate on the body diagram where your symptoms are located.



Describe your symptoms in your own words:
____

Describe how and when your symptoms began:
____

Please indicate your pain level at rest:
No pain 0 1 2 3 4 5 6 7 8 9 10 maximum pain

Please indicate your pain level when you are using painful body parts:
No pain 0 1 2 3 4 5 6 7 8 9 10 maximum pain
Frequency of Symptoms: Occasional Frequent Constant

What aggravates your symptoms?
____

What eases your symptoms?
____

List activities that you are unable to do because of your current symptoms:
____

List your occupation and hobbies: _______________________________________

What are your goals for Occupational Therapy?:
____

Consent to Treatment

I hereby give my consent for the authorized personnel of Rainwater Rehabilitation to evaluate me and render subsequent treatment in accordance with the plan of care authorized by the therapist and/or physician. I authorize release of any medical information to my physician and therapist as needed to evaluate and treat me. I also authorize release of medical information to my insurance carrier as appropriate for billing purposes.

Patient Signature________________________________ Date _____________