



Rehab 3 at Marsh Brook

Date: \_\_\_\_\_

*For Office Use: COPY ONTO RED PAPER AND PLACE IN CHART*

Reviewed with patient: \_\_\_\_\_

PATIENT NAME (Please Print): \_\_\_\_\_ Telephone #: \_\_\_\_\_  
 (May we leave a message at the number above? Yes \_\_\_ No \_\_\_)

EMERGENCY CONTACT PERSON: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Primary Care MD: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**EMERGENCY DATA**

**Medical History:**

	Have Now		Had in the Past	
	Yes	No	Yes	No
Heart Problems (angina)	_____	_____	_____	_____
Lung Disease (asthma, COPD)	_____	_____	_____	_____
Liver Disease (hepatitis, cirrhosis)	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Blood Clots, Circulation Problems	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Seizures, Fainting (syncope)	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____
Numbness or Tingling (arms/ legs)	_____	_____	_____	_____
Unexpected Weight Loss or Gain	_____	_____	_____	_____
Cancer (location: _____)	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____
Bruises Easily (anemia)	_____	_____	_____	_____
Multiple Sclerosis	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____

**FOR OFFICE USE ONLY**

Precautions (i.e. pacemaker, THR): \_\_\_\_\_

What medications are you currently taking? Please include herbs and vitamins. \_\_\_\_\_

Please list surgeries (i.e. tonsillectomy): \_\_\_\_\_

Other Medical Problems: \_\_\_\_\_

**ALLERGIES** (Please list): \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Current Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Do you smoke? Yes \_\_\_ No \_\_\_ If so, how many packs per week? \_\_\_\_\_

Do you drink? Yes \_\_\_ No \_\_\_ If so, how much per day? \_\_\_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Divorced \_\_\_

Children? Yes \_\_\_ No \_\_\_ How many? \_\_\_\_\_ Women: Are you currently pregnant? Yes \_\_\_ No \_\_\_

Type of work: \_\_\_\_\_ Retired? Yes \_\_\_ No \_\_\_

Is there anything else you would like your therapist to know about? \_\_\_\_\_