Adient Health

Patient Medical History

Patient Info & Physician Info

Name: _____ Occupation: _____

Referring Physician: _____

Family Physician:

Injury Information

Date of First Doctors Visit for this injury: ___/___/___

Last Date Worked Due to this Injury: ___/___/___

Date Returned to Work After this Injury: ___/___/___

Have you had Surgery for this Injury? ___ Y or N ___ Number of Surgeries: _____

Type of Surgery: Is there an Attorney Involved: Y or N

Prescription Information

Are you currently taking any Prescription Medication or Non-Prescription Medication Y or N

Pain Medication _____ Please List Medications you are Currently using.

Muscle Relaxers _____

Anti-Inflammatories

Service Information

Have you had previous Physical Therapy or Rehabilitation Services? Y or N

Have you had any of the following Medical or Rehab Services for your current Injury?

Emergency Room Care	_____	Podiatrist	_____
Occupational Therapy	_____	General Practitioner	_____
Chiropractor	_____	MRI	_____
Physical Therapy	_____	X-Rays	_____
Massage Therapy	_____	Orthopedist	_____
EMG/NCV	_____	Neurologist	_____
Myelogram	_____	CT-Scan	_____
Other			

Do you have any of the following?

Shortness of Breath/Chest Pain	_____	Do you Smoke?	_____
Asthma, Bronchitis or Emphysema	_____	Weight Loss/Energy Loss	_____
High Blood Pressure	_____	Are you Pregnant?	_____
Heart Attack or Surgery	_____	Allergies	_____
Coronary Heart Disease or Angina	_____	Hernia	_____
Do you have a Pacemaker?	_____	Severe or Frequent Headaches	_____
Stroke/TIA	_____	Numbness or Tingling	_____
Blood Clot/Emboli	_____	Weakness	_____
Thyroid Trouble/Goiter	_____	Vision or Hearing Difficulties	_____
Epilepsy/Seizures	_____	Dizziness or Fainting	_____
Anemia	_____	Ringing in your Ears	_____
Diabetes	_____	Pin or Metal Implants	_____
Infectious Diseases	_____	Neck Injury/Surgery	_____
Cancer or Chemotherapy/Radiation	_____	Joint Replacement	_____
Osteoporosis	_____	Shoulder Injury/Surgery	_____
Arthritis/Swollen Joints	_____	Back Injury/Surgery	_____
Gout	_____	Elbow/Hand Injury/Surgery	_____
Emotional/Psychological Problems	_____	Knee Injury/Surgery	_____
Sleeping Problems/Difficulties	_____	Leg/Ankle/Foot Injury/Surgery	_____
Bowel or Bladder Problems	_____	Tuberculosis	_____

Please list any other information that is important to your care. _____

Patient / Guardian Signature: _____ Date: ___/___/___