BACKGROUND INFORMATION & MEDICAL HISTORY FORM

EXCEL REHABILITATION & SPORTS THERAPY

To ensure you receive a complete and thorough evaluation, please provide us with information regarding your health status found on this form. If you do not understand a question, leave the area blank and your therapist will assist you.

Name: _____ Date: _____

Are you currently : ☐ Working at your usual job with no restrictions. ☐ Working at your job with restrictions.

☐ Unable to work because of your condition since : _____ ☐ Unable to work due to other medical reasons.

☐ Retired/Unemployed/Homemaker Have you ever had physical therapy for this condition? ☐ Yes | ☐ No

Are you currently seeing: If yes, when _____

☐ Medical Doctor ☐ Dentist ☐ Psychiatrist/Psychologist ☐ Osteopath ☐ Physical Therapist ☐ Chiropractor

If you have seen any of the above during the last three months, please describe reason (illness, medical conditions, injury, routine physical etc.)

_____

_____

Have you EVER been diagnosed as having any of the following conditions?

☐ Yes | ☐ No	Heart Problems	☐ Yes | ☐ No	Hearing Loss/Disorder	☐ Yes | ☐ No	Cancer
☐ Yes | ☐ No	High Blood Pressure	☐ Yes | ☐ No	Eye Disease	If yes, what kind:_____	
☐ Yes | ☐ No	Stroke	☐ Yes | ☐ No	Muscle Disease/Disorder		
☐ Yes | ☐ No	Rheumatoid Arthritis	☐ Yes | ☐ No	Multiple Sclerosis	☐ Yes | ☐ No	Past Pregnancy
☐ Yes | ☐ No	Other Arthritic Problems	☐ Yes | ☐ No	Hepatitis	Delivery: ☐ Vaginal ☐ Caesarian	
☐ Yes | ☐ No	Epilepsy	☐ Yes | ☐ No	Kidney Disease	Currently Pregnant?____months	
☐ Yes | ☐ No	Lung Disease	☐ Yes | ☐ No	Thyroid Problems		
☐ Yes | ☐ No	Emphysema/Bronchitis	☐ Yes | ☐ No	Depression	Other:_____	
☐ Yes | ☐ No	Asthma	☐ Yes | ☐ No	Circulatory Problems	☐ Yes | ☐ No	Latex Allergy
☐ Yes | ☐ No	Chemical Dependency	☐ Yes | ☐ No	Osteoporosis	☐ Yes | ☐ No	Skin Infections (MRSA/Ringworm/Shingles)

Please List any surgeries or other conditions for which you have been hospitalized, including dates and reasons.

Date: _____ Surgery: _____ Reason: _____

Date: _____ Surgery: _____ Reason: _____

Date: _____ Surgery: _____ Reason: _____

Please describe any injuries for which you have been treated (fractures, dislocations,sprains/strains).

_____

_____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for the following?

☐ Yes | ☐ No	Diabetes	☐ Yes | ☐ No	Epilepsy	☐ Yes | ☐ No	Cancer
☐ Yes | ☐ No	Heart Disease	☐ Yes | ☐ No	Chemical Dependency	☐ Yes | ☐ No	Headaches
☐ Yes | ☐ No	High Blood Pressure	☐ Yes | ☐ No	Tuberculosis	☐ Yes | ☐ No	Mental Illness

Which of the following OVER THE COUNTER medications have you taken in the past week:

☐ Yes | ☐ No	Aspirin	☐ Yes | ☐ No	Decongestants	☐ Yes | ☐ No	Antihistamines
☐ Yes | ☐ No	Advil/Motrin/Ibuprofin	☐ Yes | ☐ No	Antacids	☐ Yes | ☐ No	Vitamins/Mineral
☐ Yes | ☐ No	Tylenol	☐ Yes | ☐ No	Laxatives		Supplements

List all Prescription Medications you are currently taking (pills, injections, and skin patches):

_____

_____

Medicine Allergies: _____

How Much Caffeine per day? _____ Cigarettes smoked per day? _____ Days a week you drink alcohol? _____

Have you recently noted:

☐ Yes | ☐ No	Weight Loss/Gain	☐ Yes | ☐ No	Nausea	☐ Yes | ☐ No	Fatigue
☐ Yes | ☐ No	Weakness	☐ Yes | ☐ No	Fever/ Chills/ Sweats	☐ Yes | ☐ No	Numbness or Tingling

Form Reviewed with patient: ☐ Yes | ☐ No Therapists Signature _____ Date: _____