REHABILITATION ASSOCIATES, INC.
MEDICAL DATABASE

Patient Name: _____ DOB: _____
Referring MD: _____Patient Email Address: _____

Medical History: Please indicate whether you have been diagnosed with or treated for any of the following:

☐ Seizures	☐ Stroke/Head Injury	☐ Visual Problems	☐ Dizziness
☐ Headaches	☐ High Blood Pressure	☐ Heart Problems / Pacemaker	☐ Lung / Breathing Problems
☐ Cancer:_____	☐ Diabetes / Neuropathy	☐ Gastrointestinal Problems	☐ Vein/Artery Problems
☐ Fractures:_____	☐ Arthritis/ Osteoporosis	☐ High Cholesterol	☐ MRSA or C. Difficile (C. Diff)
☐ Pneumonia	☐ Swallowing Problems	☐ Loss of Balance	

☐ Other Medical Conditions (thyroid, lupus, MS, Lyme disease etc.):_____

Have you had this problem before? ☐ Yes ☐ No If yes, was it treated? ☐ Yes ☐ No
If yes, how: ☐ Therapy ☐ Injection ☐ Chiropractic ☐ Acupuncture ☐ Holistic ☐ Other _____
Have you had any diagnostic tests performed? ☐ X-Rays ☐ MRI ☐ Scans ☐ Other_____
Did you have surgery for this problem? ☐Yes☐ No; **If yes, when?** _____
Do you have plates or screws as a result of the surgery? ☐ yes ☐no

Health Habits and Lifestyle:

- Do you smoke? ☐ No ☐ Yes: How much?_____ Do you drink alcohol? ☐ No ☐ Yes: How much?____
- Height ____ Weight____ Have you gained/lost weight in past year? ☐ No ☐ Yes: How much?_____
- Do you exercise at a gym/pool, do Yoga/Pilates/Other? ☐ Yes ☐ No Do you play sports? ☐ Yes ☐ No

Social /Occupational: Please check all roles in which you participate: ☐ Employee ☐ Parent ☐ Caretaker ☐ Student ☐ Retiree Describe your responsibilities: _____
List the /interests in your life_____

Other Limitations: Is there any possibility you may be pregnant at this time? ☐ Yes ☐ No
Do you have a permanent disability rating? ☐ Yes ☐ No If yes, for what? _____

Are you receiving home care services at this time? ☐ No ☐ Yes

If **YES,** name of homecare agency: _____

Medications: List all medications & supplements you take: ☐ None ☐ See Attached List

List ALL Allergies: _____
Date of next appointment with your referring physician: _____
I verify that the information provided above is accurate to the best of my knowledge.

Patient Name: _____ Patient Signature: _____

_____

☐ **THIS DOCUMENT WAS REVIEWED BY: _____**
Medical Director

Appointment Reminders: Offered by email or text, please choose one option below:
☐ Email: _____
☐ Text: Phone Number: _____ Carrier: _____