

Rehabilitation Associates, Inc.

Medical Database

Date: _____ Patient Name: _____ Date of Birth: _____ MD: _____

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

| | | | |
|---|---|--|--|
| <input type="checkbox"/> COVID-19 | Dates of COVID Vaccine | #1 _____ | #2 _____ |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke/Head Injury | <input type="checkbox"/> Visual Problems | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Problems/Pacemaker | <input type="checkbox"/> Lung/Breathing Problems |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Diabetes/Neuropathy | <input type="checkbox"/> Gastrointestinal Problems | <input type="checkbox"/> Vein/Artery Problems |
| <input type="checkbox"/> Fractures: _____ | <input type="checkbox"/> Arthritis/Osteoporosis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> MRSA or C. Diff |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Swallowing Problems | <input type="checkbox"/> Loss of Balance | |
| <input type="checkbox"/> Other medical problems (thyroid, lupus, MS, lyme disease, etc.): _____ | | | |

List of all surgeries with dates: _____

List all allergies: _____

Have you had this problem before? Yes No If yes, was it treated? Yes No
If yes, how was it treated? Therapy Injection Chiropractic Acupuncture Holistic Other

Have you had any Diagnostic Tests Performed? x-ray 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 surgery? Yes No

Health Habits and Lifestyle:

Do you smoke/vape? No Yes - how much? _____ Do you drink Alcohol? No Yes - how much? _____

Height: _____ Weight: _____ Have you gained/lost weight in the 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: Check all roles that pertain to you:

Employee Parent Caretaker Student Retiree

Describe your responsibilities: _____

List hobbies/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? No Yes If yes, for what? _____

Are you receiving home care services at this time? No Yes Agency Name: _____

Medications: None See attached list

Date of next appointment with referring MD: _____

I verify that the information provided above is accurate to the best of my knowledge.

Patient Name: _____ **Patient Signature:** _____

Appointment Reminders: Offered either by email or text, please choose one option below:

Email: _____

Text: phone number: _____ Carrier: _____

No appointment reminders

This document was reviewed by: _____ (Medical Director)