Rehabilitation Associates, Inc. **Medical Database**

Date: ___________ **Patient Name:** ____________________ **Date of Birth:** __________

Chosen Name (if different from legal name)/Nickname: ____________________________________

Legal Sex: ____________ While we recognize a number of sexes/genders, unfortunately, many insurance companies and legal entities do not. Please understand that the legal name and sex listed on your insurance card must be used on documents pertaining to insurance and billing. If your name used and/or pronouns are different from these, please let us know.

Pronouns (if comfortable sharing): ___________________________

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

Dates of COVID Vaccine #1 ___________ **#2** ____________

__ 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. Diff
__ Pneumonia	__ Swallowing Problems	__ Loss of Balance	__ **COVID-19**

__ Other medical problems (thyroid, lupus, MS, lyme disease, etc.): ____________________________________

List of all surgeries with dates: ____

List all allergies: ____

<u>Have you had this problem before?</u> __ Yes __ No If yes, was it treated? __ Yes __ No

If yes, how was it treated? __ Therapy __ Injection __ Chiropractic __ Acupuncture __ Holistic __ Other

<u>Have you had any Diagnostic Tests Performed?</u> __ x-ray __ MRI __ Scans __ Other

<u>Did you have surgery for this problem?</u> __Yes __ No If yes, when? ______________

Do you have plates or screws as a result of surgery? __ Yes __ No

<u>Health Habits and Lifestyle:</u>

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

<u>Social/Occupational:</u> Check all roles that pertain to you:

__ Employee __ Parent __ Caretaker __ Student __ Retiree

Describe your responsibilities: ____

List hobbies/interests in your life: ____

<u>Other Limitations:</u> 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: ___________________________

<u>Medications:</u> __ None __ See attached list

Referring MD: _____________________________ **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:** ___________________________________

__ **This document was reviewed by:** _______________________________________ **(Medical Director)**

9/30/21