To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. All information is considered confidential and will be released only to your physician unless prior written authorization is given. Thank you.

NAME: _____ OCCUPATION: _____

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Have you seen any of the following for your current condition within the past year? (Check box)

- ☐ Physician (M.D., D.O.)
- ☐ Psychiatrist/Psychologist
- ☐ Attorney
- ☐ Dentist
- ☐ Physical Therapist
- ☐ Chiropractor

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

- ☐ Cancer, If YES, describe what kind:_____
- ☐ Heart Problems
- ☐ Pacemaker
- ☐ Circulation Problems
- ☐ High Blood Pressure
- ☐ Lung Disease
- ☐ Asthma
- ☐ Diabetes
- ☐ Rheumatoid Arthritis
- ☐ Other Arthritic Conditions
- ☐ Osteoporosis
- ☐ Kidney Disease
- ☐ Thyroid Problems
- ☐ Stroke
- ☐ Prostate Problems
- ☐ Epilepsy/Seizure Disorders
- ☐ Depression
- ☐ Sexual Transmitted Diseases
- ☐ Fibromyalgia
- ☐ Chemical Dependency (i.e. alcoholism)
- ☐ Anemia
- ☐ Ulcers
- ☐ Liver Disease
- ☐ Tuberculosis
- ☐ Allergies
- ☐ Latex Allergy
- ☐ Other:_____

Please list any surgeries or other conditions for which you have been hospitalized within the last few years, including the approximate date of the surgery or hospitalization:

DATE	SURGERY/HOSPITALIZATION	DATE	SURGERY/HOSPITALIZATION
_____	_____	_____	_____
_____	_____	_____	_____

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains) within the last few years and the approximate date of injury:

DATE	INJURY	DATE	INJURY
_____	_____	_____	_____
_____	_____	_____	_____

Have you recently noted:

- ☐ Weight loss/gain
- ☐ Fatigue
- ☐ Fever/chills/sweats
- ☐ Nausea/vomiting
- ☐ Dizziness
- ☐ Pain at night
- ☐ Weakness
- ☐ Shortness of breath
- ☐ Difficulty swallowing
- ☐ Numbness/tingling
- ☐ Headaches
- ☐ Change of appetite

Please provide your current height: _____ inches weight: _____ lbs.

Have you fallen within the past 12 months? Yes No

During the past month, have you often been bothered by feeling down, depressed, or hopeless? Yes No
During the past month, have you often been bothered by little interest or pleasure in doing things? Yes No
Have you had any recent changes in your bowel or bladder function? Yes No

How many packs of cigarettes do you smoke a day? _____

If one drink equals one beer or glass of wine, how much alcohol do you drink in a week? _____

How are you able to sleep at night? ☐ Fine ☐ Moderate difficulty ☐ Only with medications

OVER

On the scales below, please circle the number which best represents your pain levels:

At Worst:	No Pain	0	1	2	3	4	5	6	7	8	9	10 Worst Pain Imaginable
Current:	No Pain	0	1	2	3	4	5	6	7	8	9	10 Worst Pain Imaginable
At Best:	No Pain	0	1	2	3	4	5	6	7	8	9	10 Worst Pain Imaginable

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

1. _____

2. _____

3. _____

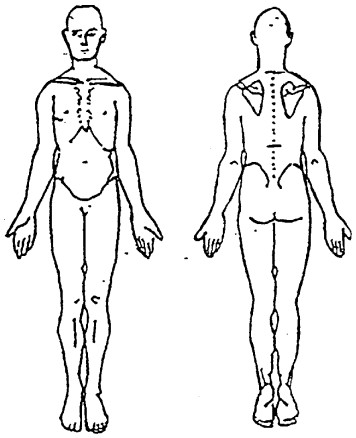
Exercise/Physical Activity Level

Completely Sedentary High Level Training Program

0 1 2 3 4 5 6 7 8 9 10

Would you like education/advice on how to safely improve your exercise/activity level? _____ Yes _____ No

Body Chart: Please mark your present symptoms on the Body Chart.



Please list any PRESCRIPTION medication (including dosages) you are currently taking (INCLUDING injections, and/or skin patches):

MEDICATION	DOSAGE	MEDICATION	DOSAGE
_____	_____	_____	_____
_____	_____	_____	_____

Which of the following OVER-THE-COUNTER medications have you taken in the last week? (Check the box.)

- ☐ Aspirin
- ☐ Tylenol
- ☐ Decongestants
- ☐ Laxatives
- ☐ Antacids
- ☐ Antihistamines
- ☐ Vitamins/mineral supplements
- ☐ Advil/Motrin/Ibuprofen
- ☐ Other

Have you been seen by a home health agency within the last 60 days? _____ yes _____ no

How did you hear about Northern Rehab?

☐ Physician ☐ Family/Friend _____ ☐ Previous Patient ☐ Social Media _____

☐ Newspaper ☐ Saw us at an Event _____ ☐ Internet Search ☐ Drive-by

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Therapist Use

Form reviewed with patient? YES ☐ NO ☐

_____ _____

Date Therapist signature