SALEM REHABILITATION ASSOCIATES

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Welcome to Salem Rehabilitation Associates.
Please complete this medical history form and return it to our office.
It must be received two business days before your appointment to avoid rescheduling your appointment.

Appointment date: _____ Time:_____
with Dr. _____

Today's date: _____

Last name: _____ First name: _____
Race: _____ Ethnicity: _____
Date of birth: _____ Gender: _____
Date of injury or onset of problem: _____
Date of Surgery (if applicable): _____

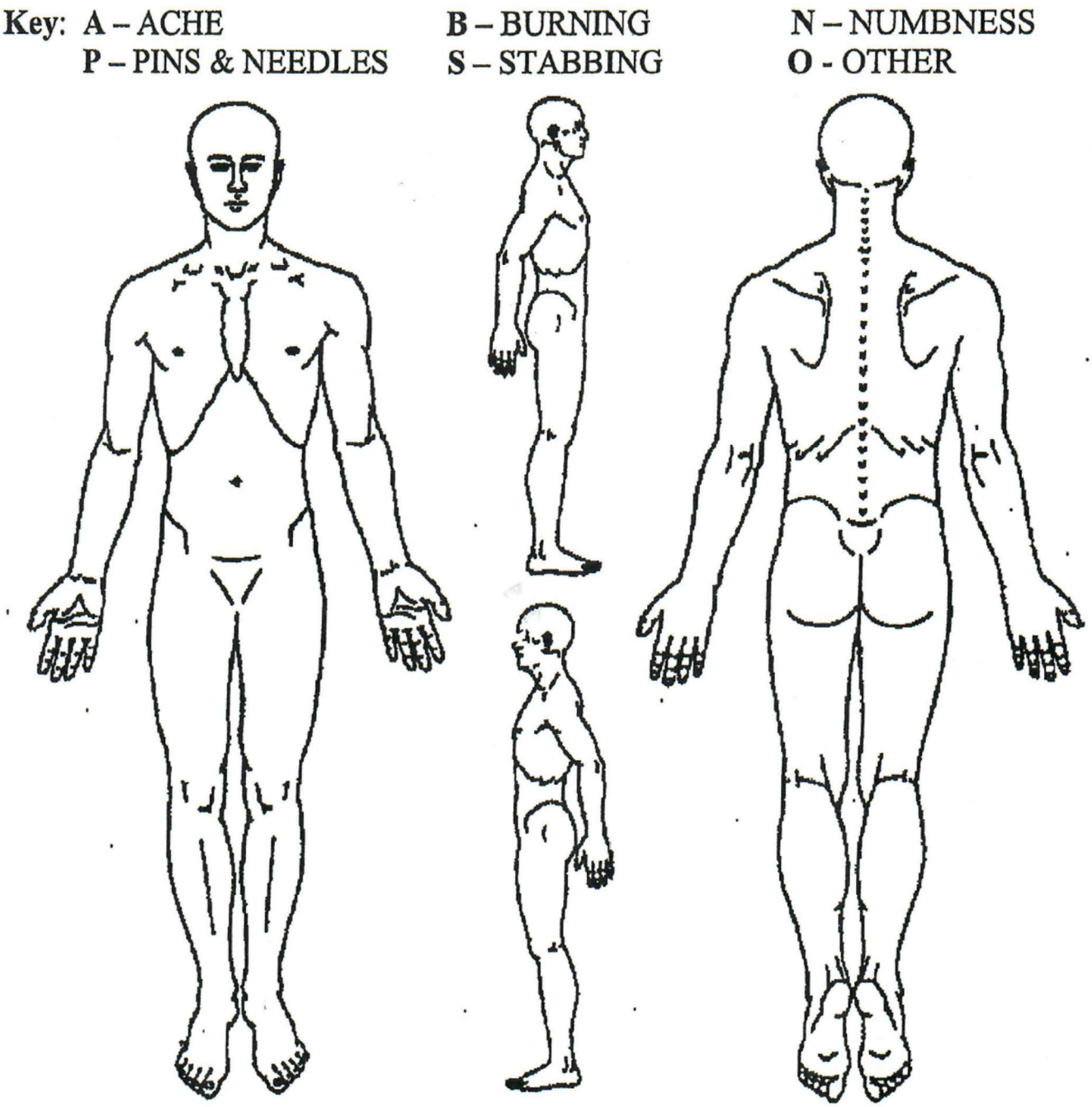
Briefly describe the problem you were referred for:
_____
_____

If you have had this problem before, enter the date: _____
What increases your symptoms:
_____
_____
What decreases your symptoms:
_____
_____

On a scale of 0 to 10 (0 being no pain and 10 being severe pain), how would you rate your pain?
Please circle. 0 1 2 3 4 5 6 7 8 9 10

PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.



Please list your current medication and supplements. It is important that you include your dose and frequency. Add additional pages if necessary.

Medication	Dose	How many per day	How often per day

Please list any allergies to medications and your adverse reaction to the medication.

Medication	Reaction

Please review the following and indicate all that apply to you by placing a checkmark in the associated box and by filling in the blank when applicable.

REVIEW OF SYSTEMS Check all that apply:

Constitutional

☐ Activity change ☐ Fever ☐ Irritability ☐ Weakness
☐ Chill/shakes ☐ Insomnia ☐ Lethargy (decreased energy)
☐ Decreased appetite ☐ Weight gain How much: ____ ☐ Malaise (vague feeling of discomfort)
☐ Fatigue ☐ Weight loss How much: ____ ☐ Night sweats

Head, Ears, Eyes & Throat

☐ Headache Describe: _____
☐ Visual changes ☐ Double vision ☐ Decreased vision ☐ Spots, flashing, etc.
☐ Hard of hearing ☐ Tinnitus (ringing in ears)
☐ Difficulty swallowing ☐ Choking ☐ Difficulty drinking liquids ☐ Difficulty eating solids
☐ Change in voice Describe: _____

Respiratory/Thorax

☐ Pleuritic pain (painful breathing) ☐ Shortness of breath ☐ Wheezing

Cardiovascular

☐ Chest pain with: ☐ Exertion ☐ Resting ☐ Both Location: _____
☐ Edema (swelling) of: ☐ Hands ☐ Feet
☐ Palpitations (irregular heart beat)

Vascular
☐ Claudication (pain in legs or buttocks with walking) ☐ Ulcers (sores on feet)
☐ Cyanosis (purple or dark blue feet, legs and/or toes) Location: _____

☐ Erythema (Redness of limbs) Location: _____
☐ Blood clots Location: _____ When: _____

Gastrointestinal
☐ Abdominal pain ☐ Altered bowel habits Describe: _____
☐ Black stools

Genitourinary
☐ Dysuria (painful urination) ☐ Incontinence (inability to control urine excretion)
☐ Hematuria (blood in urine) ☐ Increased urgency
☐ Increased frequency of urination How often: _____

Metabolic/Endocrine
☐ Cold intolerance ☐ Heat intolerance ☐ Hair loss ☐ Coarse hair ☐ Change in sleep/wake cycle
☐ Generalized weakness ☐ Polydipsia (excessive thirst) ☐ Polyphagia (excessive hunger)

Neurology/Psychology
☐ Difficulty speaking ☐ Aphasia (difficulty finding words or use of wrong or nonsense words)
☐ Dysarthria (difficulty pronouncing words) ☐ Gait (walking) disturbance Describe: _____
☐ Focal weakness in: (Please circle which limb(s)) ☐ Arm Left/Right ☐ Leg Left/Right ☐ Face Left/Right
☐ Incoordination Where: _____ ☐ Paresthesias (numbness/tingling) Where: _____
☐ Lightheadedness/Dizziness ☐ Fainting spells ☐ Vertigo (sense of room spinning) ☐ Irritable
☐ Frequently tearful ☐ Decreased sense of self-worth ☐ Feelings of guilt ☐ Loss of pleasure
☐ Decreased energy ☐ Thoughts of harming yourself or others

Dermatologic
☐ Hair changes Describe: _____ ☐ Nail changes Describe: _____
☐ Rash Where: _____ Describe: _____ ☐ Pruritis (itching)

Hematologic
☐ Easy bruising ☐ Bleeding problems Describe: _____
☐ Lymphadenopathy (swollen glands)

Musculoskeletal
☐ Back pain in: ☐ Upper region ☐ Lower region ☐ Neck pain
☐ Myalgias (muscle pain) ☐ Rheumatologic manifestations (hot/red/swollen joints) Where: _____
☐ Joint pain in:(Please circle which side(s)) ☐ Shoulder Left/Right ☐ Elbow Left/Right
☐ Wrist Left/Right ☐ Fingers Left/Right
☐ Hip Left/Right ☐ Knee Left/Right
☐ Ankle Left/Right ☐ Feet/Toes Left/Right

Immunological
☐ Allergy to tape ☐ Allergy to latex ☐ Allergy to : _____

PAST MEDICAL & FAMILY HISTORY Have you or a family member ever been diagnosed with the following?

Rheumatological	You	Father	Mother	Brother	Sister
Rheumatoid Arthritis					
Osteoarthritis					
Psoriatic Arthritis					
Lupus					
Vasculitis					
Other					
Cancer					
Type					
Type					
Type					
Heart/Vascular Disease	You	Father	Mother	Brother	Sister
Heart attack					
Bypass surgery					
Coronary artery disease					
Peripheral arterial disease					
High blood pressure					
Anemia					
Lung Disease					
COPD					
Asthma					
Bronchitis					
Other					
Endocrine	You	Father	Mother	Brother	Sister
Diabetes Diagnosis date:					
Thyroid disease					
Osteoporosis					
Gastrointestinal					
Stomach ulcer					
GERD/Gastritis (heartburn)					
Liver Disease					
Hepatitis A					
Hepatitis B					
Hepatitis C					
Cirrhosis					
Other					
Kidney Disease					
Renal failure					
Stones					
Other					

Neurological					
Stroke					
Multiple sclerosis					
Seizure disorder					
Peripheral neuropathy					
Carpal tunnel syndrome					
Alzheimer's disease					
Dementia					
Psychiatric					
Depression					
Bipolar disorder					
Schizophrenia					
Personality disorder					
Drug abuse Which drug(s) _____ _____					
Alcoholism					

Have ***you*** ever had any of the following:
☐ Herniated disk in: ☐ Cervical (neck) region ☐ Lumbar (low back) region Surgery date: _____
☐ Fractured spine in: ☐ Cervical ☐ Thoracic (mid back) ☐ Lumbar Surgery date: _____
☐ Injury to joint(s): (Please circle left and/or right) ☐ Shoulder Left/Right ☐ Elbow Left/Right
☐ Wrist Left/Right ☐ Hip Left/Right
Injury to joints continued: ☐ Knee Left/Right ☐ Ankle Left/Right ☐ Other _____ Left/Right

Please list any surgeries that you have had:

Surgery	Date

Is there anything else that you would like the Doctor to know about your health history?
_____

_____

SOCIAL HISTORY

☐ Right handed ☐ Left handed ☐ Ambidextrous

Highest grade completed in school: _____

Highest degree/diploma completed: _____

Employer: _____ Occupation: _____

☐ Unemployed ☐ Disabled ☐ Retired

Date last worked: _____ Retired as of: _____

☐ Single ☐ Married ☐ Significant other/Partner ☐ Divorced ☐ Widowed

☐ Children Number of children: _____

Tobacco use ☐ Current ☐ Former Year quit: _____ ☐ Never

Type of tobacco: _____

Alcohol use ☐ Current ☐ Former Year quit: _____ ☐ Never

How often do you consume alcohol: _____

Exercise ☐ Yes ☐ No

Type of exercise: _____

Frequency of exercise: _____

Are you a current health club member? ☐ Yes ☐ No

Please list any hobbies/leisure activities that you are involved in: _____

_____

☐ Please check this box if you would like to have a chaperone present during your exam with the Doctor.

_____ _____

Signature Date