Confidential Medical History

The Gait Center
LAWRENCE REHABILITATION

Full Name: (first, middle, last) _____

Date of Birth: _____/_____/_____ Chief Complaint:_____

Date of Injury/Onset of Symptoms: _____/_____/_____ Date of Surgery: _____/____/_____

Referring MD: _____

Primary Care Physician: _____

Have you had any Rehabilitation or Diagnostic Services for this injury?

□Therapy □MRI □X-rays □Other_____

Is your condition related to:

□ Auto Accident

□ Other Accident

□ Work Related

Employer:_____

List all medications you are currently taking: (or provide office with copy of list) _____

_____

Are you allergic to any medication or latex?_____

List any surgeries and year: _____

_____

Do you have (or have you had in the past) any of the following conditions? Please check all that apply.

- ☐ Anemia
- ☐ Back Pain
- ☐ Bronchitis
- ☐ Dizziness or Faintness
- ☐ Epilepsy/Seizures
- ☐ Heart Attack
- ☐ Kidney Disease
- ☐ Severe/frequent headache
- ☐ Stroke/TA
- ☐ Vision Difficulties
- ☐ Women's Health Issues
- ☐ Joint Replacement
- ☐ Pins or metal Implants
- ☐ Osteoporosis
- ☐ A Pacemaker
- ☐ Angina/Chest Pain
- ☐ Blood clot/Emboli
- ☐ Coronary Heart Disease
- ☐ Drink Alcohol
- ☐ Gout
- ☐ Hernia
- ☐ Parkinson's
- ☐ Sleeping Problems
- ☐ Thyroid Problem
- ☐ Weakness
- ☐ Arthritis
- ☐ Numbness or Tingling
- ☐ Other _____
- ☐ Allergies
- ☐ Asthma
- ☐ Bowel/Bladder problems
- ☐ Currently Pregnant
- ☐ Emphysema
- ☐ Hearing Difficulties
- ☐ High Blood Pressure
- ☐ Pneumonia
- ☐ Smoke Cigarettes
- ☐ Varicose Veins
- ☐ Weight Loss/Energy Loss
- ☐ Cancer
- ☐ Diabetes Type: 1____ 2 ____
- ☐ Other _____

Tell us, what is going on? Describe the Problem, Body Part, and specify left, right, or both.

_____

_____

_____

Have you fallen in the last 12 months? ____ Yes ____ No If yes, were you injured? _____

How many days per week do you exercise? _____ Recreation/Sports/Hobbies: _____

HEIGHT: _____ **WEIGHT:** _____ _____

Patient/Parent/Guardian Signature: _____ **Date:** _____/_____/_____