Orthopedic & Sport Rehabilitation, LLC
Patient History for Medicare Insurance

Answer all questions to the best of your ability to assist your therapist with your care.

Name _____

Height _____FT _____IN Weight _____LBS Dominant Hand: Right Left

Referring Doctor (Name/Location) _____

Internist/Family Doctor (Name/Location) _____

History of Present Illness

1. Chief Complaint (Why are you seeing us today?) _____
2. How long have you had this problem (Date Specific)? _____
3. What started this problem? _____

Please answer the following:

4. Has the problem become worse?	☐ YES	☐ NO	If Yes, Date_____
5. Is the problem the result of a car accident?	☐ YES	☐ NO	If Yes, Date_____
6. Is the problem a result of a work accident?	☐ YES	☐ NO	If Yes, Date_____
7. Did this condition result in surgery?	☐ YES	☐ NO	If Yes, Date_____
8. Have you had PT anywhere this year?	☐ YES	☐ NO	If Yes, Date_____
9. Are you currently receiving home health? (IE Any healthcare worker/aide assisting or doing something to or for you?	☐ YES	☐ NO	If Yes, Date_____
10. Do you live in a nursing home/assisted living?	☐ YES	☐ NO	If Yes, Date_____
11. Are you covered under black lung disease?	☐ YES	☐ NO	If Yes, Date_____
12. Are you covered under end stage renal disease?	☐ YES	☐ NO	If Yes, Date_____
13. Are you covered under large group insurance?	☐ YES	☐ NO	If Yes, Date_____
14. Are you covered under veterans affairs?	☐ YES	☐ NO	If Yes, Date_____

Signs associated with your problem:
(Check *all that apply)*

Sign	Location	Sign	Location
☐ Swelling/Edema	_____	☐ Muscles Atrophy	_____
☐ Redness/Warmth	_____	☐ Muscle Spasm/Twitch	_____
☐ Skin Changes/Bruising	_____	☐ Loss of Movement	_____
☐ Numbness/Tingling	_____	☐ Other	_____

Describe the quality of your pain? (*Check All That Apply)*

☐Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Aching
☐ Dull ☐ Throbbing ☐ Continuous ☐ Intermittent ☐ Other_____

Does anything make your problem better? ☐ YES ☐ NO

If yes, please list: _____

Rate your pain severity using the following scale: *(Check a number)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Treatments for your chief complaint have included: ***(Check all that apply)***

☐ Physical Therapy	☐ NSAID Medication
☐ Occupational Therapy	☐ Ice/Heat
☐ Massage Therapy	☐ Pain Medication
☐ Chiropractic Treatments	☐ Other:_____

Tests done to evaluate your problem: ***(Check all that apply)***

Test	**Area Tested**	**Date**	**Location**
X-Rays			
CT Scan			
MRI			
Bone Scan			
EMG			

Current Symptoms: (*Check all that apply)*

☐ Fever	☐ Recent Weight Change	☐ Poor Circulation	☐ Chills
☐ Weakness of Extremities	☐ Very Low Energy	☐ Back Pain	☐ Currently Pregnant
☐ Frequent Headaches	☐ Dizziness	☐ Change in Bowel Function	☐ Heart/Chest Pain
☐ Poor Balance	☐ Change in Urine Function	☐ Abnormal Heart Beat	☐ Broken Bones
☐ Chest Pain with Breath	☐ Neck Pain	☐ Shortness of Breath	☐ Other_____

Medical History (*Check all that apply)*

☐ Allergies	☐ Cardiac Pacemaker	☐ Emphysema	☐ Kidney Problems	☐ Thyroid Disease
☐ Anemia	☐ Chem. Dependency	☐ Bronchitis	☐ Metal Implants	☐ Tuberculosis
☐ Anxiety	☐ Circulation Issues	☐ Fractures	☐ Multiple Sclerosis	☐ Vision Problems
☐ Arthritis	☐ Currently Pregnant	☐ GallBladder Issues	☐ Osteoporosis	
☐ Asthma	☐ Depression	☐ Hepatitis	☐ Parkinsons	
☐ Cancer	☐ Diabetes	☐ High Blood Pressure	☐ Seizures	
☐ Cardiac Conditions	☐ Dizzy Spells	☐ Incontinence	☐ Strokes	

Describe any other conditions or precautions: _____

Surgical History: (*If list of surgeries is provided to front desk, please check the appropriate box below.)*

Body Region (IE Neck/Throat)	**Surgery Type (IE Tonsillectomy)**	**Date (MM/DD/YYYY)**

☐***I have provided a list of surgeries to the front desk.***

Patient Initials_____

Current Medications: (*If list of medications is provided to front desk, please check appropriate box below)*

Drug Name (IE Doxycycline)	**Dosage (IE 50mg)**	**Frequency (IE Once Daily)**	**Method of Administration (IE Orally)**	**Reason for Taking (IE Arthritis)**
☐ ***I have provided a list of medications to the front desk.***				

Work Status: ☐ Retired ☐ Employed Full-Time ☐ Employed Part-Time
Marital Status: ☐ Single ☐ Married ☐ Other

My Signature confirms I have answered the above questions truthfully, and to the best of my ability.

Patient Signature: _____ Date _____
(Parent/Guardian if under 18 years old)