

**Past Medical History**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Date of injury/onset of pain: \_\_\_\_\_

How did the injury occur/ when did the pain start? \_\_\_\_\_

Do you have an attorney representing you as a result of this injury/pain? \_\_\_ Yes \_\_\_ No

Name of Attorney \_\_\_\_\_

List the current medications (including herbal supplements) that you are taking presently:

\_\_\_\_\_  
\_\_\_\_\_

Past Surgeries and dates: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is there a medical reason that you should not exercise? \_\_\_ Yes \_\_\_ No

If Yes, please explain \_\_\_\_\_

**Do you have a past history of: Yes No When/How long?**

Alcohol consumption \_\_\_\_\_ amount per day Quit Date \_\_\_\_\_

Smoking \_\_\_\_\_ amount per day Quit Date \_\_\_\_\_

Heart disease \_\_\_\_\_

High blood pressure \_\_\_\_\_

Cancer \_\_\_\_\_

Diabetes \_\_\_\_\_ Type 1 \_\_\_\_\_ Type 2 \_\_\_\_\_

Depression \_\_\_\_\_

Over the past 2 weeks have you felt down/hopeless? \_\_\_ Yes \_\_\_ No

Over the past 2 weeks, have you felt little interest/pleasure in doing things? \_\_\_ Yes \_\_\_ No

Seizures \_\_\_\_\_

Angina \_\_\_\_\_

Stroke \_\_\_\_\_

Psychiatric Disorders \_\_\_\_\_

Pregnant currently \_\_\_\_\_

Liver Disease \_\_\_\_\_

Breathing/Lung Problems \_\_\_\_\_

Heart surgery \_\_\_\_\_

Heart Palpitations \_\_\_\_\_

Infectious blood disease \_\_\_\_\_

Known Allergies \_\_\_\_\_

Other \_\_\_\_\_

What are your goals for rehabilitation? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you need a vocational counselor? \_\_\_ Yes \_\_\_ No

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_