Guelph Rehab Centre
INNOVATIVE HEALTHCARE

MEDICAL HISTORY / INITIAL EVALUATION FORM

PATIENT INFORMATION DATE_____

NAME_____

AGE_____ HEIGHT_____ WEIGHT_____lbs

EMPLOYER_____ CURRENTLY EMPLOYED? YES (FT OR PT) NO MODIFIED

REHAB INFORMATION

1. CHIEF COMPLAINT/AILMENT/INJURY_____
2. DATE OF INJURY_____ DATE OF SURGERY_____
3. BRIEFLY DESCRIBE HOW YOU WERE INJURED

   _____

   _____
4. HAVE YOU RECEIVED THERAPY FOR THIS CONDITION? ☐ YES ☐ NO WHEN? _____
   HOW MANY VISITS? _____
5. HAS YOUR CONDITION BEEN GETTING: ☐ WORSE ☐ SAME BETTER
6. ARE YOUR SYMPTOMS: ☐ CONSTANT OR ☐ INTERMITTENT
7. MARK THE NUMBER THAT BEST CORRESPONDS TO YOUR PAIN:

AT BEST:	0	1	2	3	4	5	6	7	8	9	10 (EXCRUCIATING PAIN)
AT WORST:	0	1	2	3	4	5	6	7	8	9	10 (EXCRUCIATING PAIN)

8. WHAT DECREASES/MAKES YOUR CONDITION BETTER? (MARK ALL THAT APPLY)

☐ BENDING	☐ MOVEMENT	☐ REST	☐ BETTER IN AM
☐ SITTING	☐ STANDING	☐ HEAT	☐ BETTER AS DAY PROGRESSES
☐ RISING	☐ WALKING	☐ ICE	☐ BETTER IN PM
☐ CHANGING POSITIONS	☐ LYING	☐ MEDICATION	☐ N/A CAST JUST REMOVED

9. WHAT INCREASES/MAKES YOUR CONDITION WORSE? (MARK ALL THAT APPLY)

☐ BENDING	☐ MOVEMENT	☐ REST	☐ SNEEZE
☐ SITTING	☐ STANDING	☐ STAIRS	☐ DEEP BREATH
☐ RISING	☐ WALKING	☐ COUGH	☐ MEDICATION
☐ PROLONGED POSITIONING	☐ LYING	☐ WORSE IN AM	☐ WORSE IN PM
☐ WORSE AS DAY PROGRESSES	☐ N/A CAST JUST REMOVED		

10. PREVIOUS MEDICAL INTERVENTION (MARK ALL THAT APPLY)

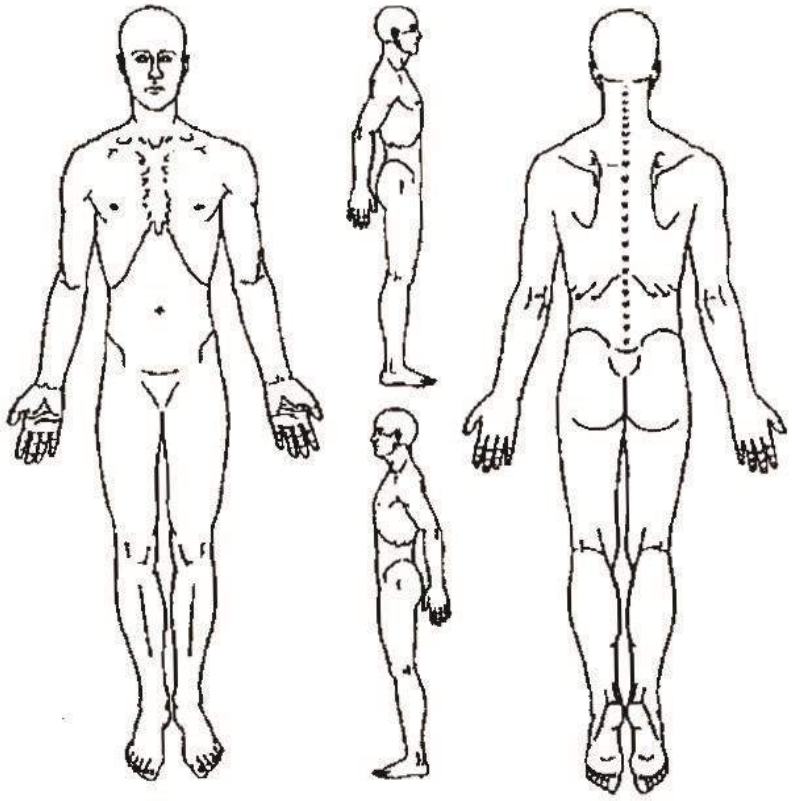
    ☐ X-RAY MRI ☐ CATSCAN ☐ INJECTIONS OTHER_____

11. WHAT ARE YOUR GOALS TO BE ACHIEVED BY THE END OF THERAPY?

    _____

    _____

DRAW IN AREAS OF PAIN ON BODY DIAGRAMS USING APPROPRIATE SYMBOLS. If you are completing this form on the computer, print form after completion and mark the diagram with a pen.



SEVERE PAIN	*******
MODERATE PAIN	00000000
DULL ACHE	∩∩∩∩∩∩
RADIATING PAIN	↑↓↑↓↑↓↑↓
NUMBNESS/TINGLING	XXXXXX

MEDICAL INFORMATION (MARK ALL THAT APPLY) **THIS INFORMATION IS CONFIDENTIAL AND REMAINS PART OF YOUR CHART

- ☐ DIFFICULTY SWALLOWING
- ☐ MOTION SICKNESS
- ☐ STROKE
- ☐ ARTHRITIS
- ☐ FEVER/CHILLS/SWEATS
- ☐ OSTEOPOROSIS
- ☐ HIGH BLOOD PRESSURE
- ☐ UNEXPLAINED WEIGHT LOSS
- ☐ ANEMIA
- ☐ HEART TROUBLE
- ☐ BLOOD CLOTS
- ☐ BLEEDING PROBLEMS
- ☐ PACEMAKER
- ☐ SHORTNESS OF BREATH
- ☐ HIV/HEPATITIS
- ☐ EPILEPSY/SEIZURES
- ☐ HISTORY OF SMOKING
- ☐ HISTORY OF ALCOHOL ABUSE
- ☐ HISTORY OF DRUG ABUSE
- ☐ DIABETES
- ☐ DEPRESSION/ANXIETY
- ☐ MYOFASCIAL PAIN
- ☐ FIBROMYALGIA
- ☐ CANCER

WOMEN CARE: ☐ PREGNANCY #_____ ☐ BIRTHS #_____ ☐ BIRTH CONTROL PILLS

MENOPAUSAL: _____ MENSTRUAL PROBLEMS: _____

PREVIOUS SURGERIES/HOSPITALZATION: _____

OTHER: _____

MEDICATIONS (Type & Amount):

_____

_____

SOCIAL HISTORY: ☐ ALLERGIES: _____ ☐ SMOKING: _____ ALCOHOL: SOCIALLY DAILY

REGULAR EXCERISE: ☐ YES ☐ NO **SIGNATURE:** _____