# South Peninsula Hospital Rehabilitation

907-235-0370

**Patient Information Record/Update**

Today's Date: ____________

Name: ________________________________ Date of Birth: ______________ Age: ______

Contact Phone Numbers: Work: ______________ Home: ______________ Mobile: ______________

Occupation and/or School: ________________________________

Referring Physician: ______________________ Family/Personal Physician: ______________________

Diagnosis: ____________________________ Current Medications: ______________________

________________________________________________

**Present Injury or Illness**

Please answer the following questions as fully as possible. Circle Yes or No when applicable.

1. How and when (date) did the present injury occur? ________________________________

   ________________________________________________
2. Was the onset gradual? Yes No
3. Did you undergo surgery? Yes No If yes, what was the date of surgery? ______________
4. How long were you hospitalized? ______________
5. What type of symptoms do you have? ________________________________
6. Have your symptoms changed since you last saw your doctor? (Explain on back) Yes No
7. Are you currently experiencing any chills, sweats or fever? Yes No
8. What is the present status of your condition compared to when it began? (Circle one)

   Better Worse No change
9. Are your symptoms constant or intermittent?
10. Does pain interrupt or prevent you from sleeping?

    Yes No
11. Please rate your pain on a scale from 1-10 with 1 pain free and 10 maximum pain.

    Pain level at this time _____

    Pain 1-10 at its very worst _____
12. Use the symbols below and the figures at right to diagram where your symptoms are now.

    |||| Numbness — Moderate Pain

    Severe Pain — ↓ Shooting Pain
13. Have you ever had anything similar before?

    Yes No
14. What are your goals for physical, occupational or speech therapy?

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# Medical History

**Circle and Describe When Applicable:**

1. Have you experienced unexplained weight loss in the last six months? Yes No
2. Family or personal history of diabetes? Yes No
3. Family or personal history of heart disease? Yes No

If yes, do you have congenital or acquired heart disease?

______________________________________________

**Do You Have:**

4. High blood pressure? Yes No
5. Pacemaker? Yes No
6. Hemorrhagic disease (hemophilia, purpura, or other bleeding tendencies)? Yes No
7. Allergies to medication? Yes No

Describe: ______________________________________

______________________________________________

8. Other allergies? Yes No

Describe: ______________________________________

______________________________________________

9. History of mental illness? Yes No

Describe: ______________________________________

______________________________________________

10. Respiratory illness? Yes No
11. Enlarged liver? Yes No
12. Hernia? Yes No
13. Enlarged spleen? Yes No
14. Kidney disease? Yes No
15. Metal implants? Yes No
16. Previous head trauma or repeated convulsions? Yes No
17. Surgery for head, neck, or spine? Yes No
18. Shoulder dislocation or separation? Yes No
19. Knee injury Yes No
20. Ankle injury? Yes No
21. Fractures? Yes No
22. Heat illness? Yes No
23. Acute infections? Yes No
24. Prostate problems? Yes No
25. Hormonal imbalances/problems? Yes No
26. Hysterectomy? Yes No
27. Are you pregnant now? Yes No
28. Reproductive tract problems? Yes No
29. Osteoporosis? Yes No
30. Rheumatoid arthritis? Yes No
31. Personal history of cancer? Yes No
32. Glaucoma? Yes No
33. Do you exercise at least three times a week? Yes No

Other medical conditions not listed? _________________

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Please use this space for explanations.

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