Huggins Hospital

Back Bay Rehabilitation
603.569.7565 FAX: 603.569.3026

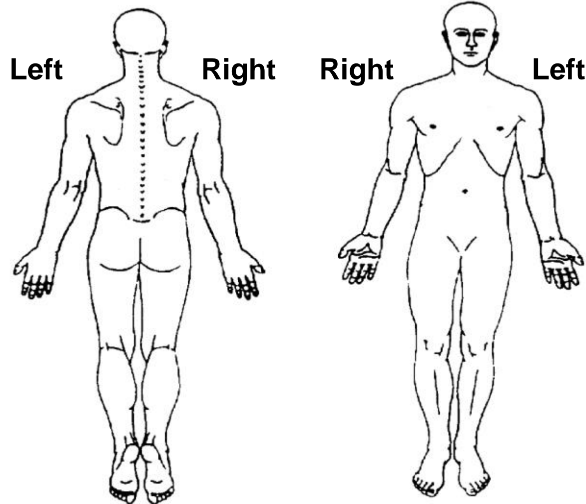
Medical History

Name: ____________________ **Diagnosis:** ____________________

Date: ____________________ **Date of Injury:** ____________________

Occupation:____________________

Where are your symptoms for which you are seeking treatment? *Mark on the drawings below the areas where you feel your symptoms.*



What was your worst pain rating within the last 2 weeks?

What makes your symptoms worse? ____________________

What, if anything, eases your symptoms? ____________________

Can you get comfortable at night? ☐ **Yes** ☐ **No** **Can you sleep through the night?** ☐ **Yes** ☐ **No**

How are your symptoms in the morning? ____________________

Once you start moving, is it… ☐ **Better** ☐ **Worse**

How are your symptoms at the end of the day? ☐ **Same** ☐ **Better** ☐ **Worse**

Are you currently receiving Visiting Nursing Services? ☐ **Yes** ☐ **No**

Is this a Worker's Compensation claim? ☐ **Yes** ☐ **No**

Have you received Physical Therapy, Occupational Therapy,
or Speech Therapy within the last 12 months? ☐ **Yes** ☐ **No** **If yes: where** ____________________

Front Desk Initials: ___________

MEDICAL HISTORY: **Do you have or have you had:**

	YES	NO		YES	NO
Asthma, Bronchitis or Emphysema	______	______	**Allergies**	______	______
Shortness of Breath	______	______	**Severe or frequent headaches**	______	______
Smoker (How much? ______________________)	______	______	**Vision or hearing difficulties**	______	______
			Do you have a history of falling?	______	______
Coronary Heart Disease or Angina/Chest pain	______	______	**Gout**	______	______
Do you have a pacemaker?	______	______	**Numbness or Tingling**	______	______
High blood pressure	______	______	**Dizziness or Fainting**	______	______
Stroke/TIA/Head Injury	______	______	**Weight Loss/Energy Loss**	______	______
Blood Clot/Emboli	______	______	**Nausea/Vomiting**	______	______
Epilepsy/Seizures	______	______	**Circulation problems (Blood Clot)**	______	______
Thyroid Trouble/Goiter	______	______	**Varicose veins**	______	______
Anemia	______	______	**Any pins or metal implants**	______	______
Infectious Diseases	______	______	**Joint replacement**	______	______
Diabetes	______	______	**Rheumatic fever**	______	______
Cancer or Chemotherapy	______	______	**Hepatitis**	______	______
Arthritis/Swollen Joints	______	______	**Lung Disease**	______	______
Bowel/Bladder Problems	______	______	**Tuberculosis**	______	______
Urinary Incontinence	______	______	**Liver Disease**	______	______

At the present time, would you say that your health is EXCELLENT, VERY GOOD, FAIR, or POOR? (Circle one)

Have you ever had this type of injury before? ☐ **Yes** ☐ **No**

If yes, have you previously had therapy for this injury? ☐ **Yes** ☐ **No** **If yes, please explain** ________________________________

MEDICATIONS **(please list all medications you are currently taking or attach a list):**

____

SURGERIES **(please list all surgeries and approximate dates):**

____

____

GOALS: **What are your goals for attending therapy**? ____

____

Women:

Are you now pregnant or possibly pregnant? ☐ **Yes** ☐ **No**

Have you been diagnosed with osteoporosis or osteopenia? ☐ **Yes** ☐ **No**

As part of our quality program, we believe that patients should be integrally involved in their rehabilitation plan. This includes being informed about the treatment recommended, as well as the goals of your program. It is important that you understand you have the right to refuse any part of the treatment your therapist recommends.

Signature: ___________________________________**Date:** ______________________

Therapist Initials: ___________
Indicates Reviewed