

Medical History and Social Service Questionnaire

Patient Name _____ Referring MD _____
Occupation _____ Family MD _____
Reason for Referral _____
Was Surgery Performed Y or N Type of Surgery _____ Date of Surgery ____/____/____
Currently Working No / Full Duty / Light Duty Date Last Worked Due to Injury ____/____/____

Medications

Anti Inflammatory Y or N Muscle Relaxers Y or N Pain Medication Y or N
Other Medications _____

Rehabilitation Services

Have you had any of the following Medical or Rehabilitation Services for **THIS** Injury ?

General Practitioner	Y or N	MRI	Y or N	Results	_____
Orthopedist	Y or N	X-Rays	Y or N	Results	_____
Neurologist	Y or N	CT Scan	Y or N	Results	_____
Podiatrist	Y or N	Arthrogram	Y or N	Results	_____
Chiropractor	Y or N	EMG/NCV	Y or N	Results	_____
Emergency Room	Y or N				
Physical Therapy	Y or N	When ?	_____	Where ?	_____

Past / Present Conditions

Respiratory Problems	Y or N	Headaches	Y or N
Shortness of Breath	Y or N	Nausea	Y or N
Chest Pain/Heart Disease	Y or N	Dizziness or Fainting	Y or N
Do you have a Pacemaker	Y or N	Numbness or Tingling	Y or N
Heart Attack	Y or N	Muscle Weakness	Y or N
Heart Surgery	Y or N	Weight Loss/Energy Loss	Y or N
Irregular Heartbeat	Y or N	Sleeping Difficulty	Y or N
Stroke / TIA	Y or N	Emotional/Psychological Problems	Y or N
Epilepsy / Seizures	Y or N	Arthritis Osteo / Rheumatoid	Y or N
Infectious Diseases	Y or N	Bowel or Bladder Problems	Y or N
Diabetes IDDM / NIDDM	Y or N	Poor Balance/History of Falls	Y or N
Cancer / Chemotherapy	Y or N	Osteoporosis	Y or N
Type of Cancer _____		Allergies	Y or N
High Blood Pressure	Y or N	Do You Smoke?	Y or N
Hearing Difficulty	Y or N	Are You Pregnant?	Y or N
Vision Difficulty	Y or N	Any Pins or Metal Implants?	Y or N
Past Two Surgeries			
Type _____		Date (Mo./Yr.) _____	
Type _____		Date (Mo./Yr.) _____	

Pain Level (0-10) 0 = No Pain 10 = Extreme Pain Current _____ At Rest _____ With Activity _____

As a component of our participation in the Medicare program, we have partnered with a professional who can provide social services to our clients and can assist them in exploring community resources available to obtain the basic necessities for living. Do you have difficulty with any of the following **as a result of your current medical condition** ?

Obtaining food or medicine	Y or N	Paying rent / utilities	Y or N
Transportation	Y or N	Safety Issues at home	Y or N
Coping with current condition	Y or N	Financial Stress	Y or N
Other _____			

Do you feel that you require any assistance from a social worker while enrolled in therapy ? Y or N

Patient / Guardian Signature _____ Date ____/____/____

Therapist Signature (reviewed form with pt.) _____ Date ____/____/____

Date social worker contacted ____/____/____ Therapists Initials _____