Name:	**Referring Physician:**

Injury / Accident / Onset Information			
Injury / Onset Details:		Injury or Onset Date:	
Occupation:		Are you currently working?	☐ N/A ☐ No ☐ Yes
Last Date Worked:	Scheduled Return to Work Date:	Is an attorney involved?	☐ N/A ☐ No ☐ Yes

Outside of normal athletics, in the past year, how many times have you fallen?	Did any falls result in an injury?

Tobacco Use: ☐ None ☐ Social ☐ Yes	Are you pregnant? ☐ N/A ☐ No ☐ Yes	Height:
Amount per day:	# of Weeks:	Weight:

Please list ALL prescription and non prescription medications you are currently taking.		
Anti Inflammatories		Other:
Muscle Relaxers		
Pain Medication		
Antibiotics		See separate list attached ☐

Please check if you have had any of the following Medical or Rehabilitative Services for THIS injury/episode:				
Chiropractor	☐	Myelogram	☐	Other:
CT Scan	☐	Neurologist	☐	
Emergency Room	☐	Occupational Therapy	☐	Additional Information:
EMG/NCV	☐	Orthopedist	☐	
General Practitioner	☐	Physical Therapy	☐	
Injections:	☐	Podiatrist	☐	
Massage Therapy	☐	Surgery:	☐	
MRI	☐	X-Rays	☐	

Please check if you NOW HAVE or if you HAVE EVER HAD any of the following:						
Allergies	☐	Hernia	☐	Vision or Hearing Difficulties	☐	Other: ☐
Anemia	☐	High Blood Pressure	☐	Weakness	☐	
Arthritis or Swollen Joints	☐	Infectious Diseases	☐	Weight Loss / Energy Loss	☐	
Asthma, Bronchitis or Emphysema	☐	Numbness or Tingling	☐	Joint Replacement	☐	
Blood Clot / Emboli	☐	Osteoporosis / Osteopenia	☐	Neck Injury and/or Surgery	☐	Additional Info:
Bowel or Bladder Problems	☐	Pacemaker	☐	Shoulder Injury and/or Surgery	☐	
Cancer /Chemotherapy /Radiation	☐	Pins or Metal Implants	☐	Elbow Injury and/or Surgery	☐	
Coronary Heart Disease or Angina	☐	Severe or Frequent Headaches	☐	Wrist Injury and/or Surgery	☐	
Diabetes	☐	Shortness of Breath / Chest Pain	☐	Hand Injury and/or Surgery	☐	
Dizziness or Fainting	☐	Sleeping Problems / Difficulties	☐	Back Injury and/or Surgery	☐	
Emotional/Psychological Problems	☐	Stroke / TIA	☐	Knee Injury and/or Surgery	☐	
Epilepsy / Seizures	☐	Thyroid Trouble / Goiter	☐	Leg Injury and/or Surgery	☐	
Gout	☐	Tinnitus / Ringing in ears	☐	Ankle Injury and/or Surgery	☐	
Heart Attack or Heart Surgery	☐	Tuberculosis	☐	Foot Injury and/or Surgery	☐	

Please list any other information that would assist us in your care:

Are you aware of your diagnosis? ☐ No ☐ Yes **Based on your awareness, what are your rehabilitation expectations and/or goals?**

Sports & Spine Rehab is an outpatient department of Methodist Hospital for Surgery, and it is our policy for all patients, during the first visit, to have an opportunity to discuss the evaluation findings and the therapist's proposed Plan of Care and have any and all questions answered satisfactorily, prior to commencing therapy.

Patient or Guardian Signature: ______________________ **Date:** ____________