Northwest Return to Work and evaluation services LLC

General Medical History

To ensure you receive a complete and thorough evaluation, please provide us with the following important background information. If you do not understand a question, leave it blank and your therapist will assist you in answering it. Thank you!

Name:____Today's Date:_________________

Date of Birth:____/_____/____ Gender: M / F Email address___________________________________

Date of Last Physical Exam: _____________ Reason: ___________________________________

List *all* allergies: Medication(s), LATEX, metals, etc. and food intolerances: ___________________

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List any implants/artificial joints/ pacemaker: _______________________________________

List all medications you have taken in the last week. **Please include prescriptions, over-the-counter, pills, injections, patches, vitamins, herbs.** Indicate if these are routine, new, or have recently changed. If the space provided is inadequate, please include complete information on a separate sheet:

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Have you been treated by any of the following in the past 3 months? ___Medical Doctor ___Osteopath ___Dentist ___ Physical Therapist ___ Chiropractor ___ Psychologist/Psychiatrist ____Other: __________________

How many beverages containing caffeine do you consume/day? ____ How many alcoholic beverages do you drink/wk? ____
Cigarette smoker? Y / N (packs/day ____ How many years?______ Have you quit smoking?_______ When?_________)

Have you or anyone in your immediate family (Parents, brothers sisters) ever been diagnosed with any of the following conditions? Please indicate a "Yes" by circling S for self. "F" for Family or "N" for Neither/No.

Cancer (Type:___________)	S F N	Asthma	S F N	Chemical Dependency	S F N
Heart Problems:	S F N	Hepatitis	S F N	Depression	S F N
High Blood Pressure	S F N	Emphysema/Bronchitis	S F N	Seizures/Epilepsy	S F N
Heart burn/indigestion	S F N	Tuberculosis	S F N	Tremors	S F N
Stroke	S F N	Kidney Disease	S F N	Rheumatoid Arthritis	S F N
Anemia	S F N	Thyroid Problems	S F N	Osteoarthritis	S F N
Blood Disorder	S F N	Post Menopause	S F N	Stomach Problems	S F N

Have you recently noted any of the following?

Unexplained weight gain/loss	YES NO	Constipation	YES NO	Problems urinating	YES NO
Nausea/vomiting	YES NO	Fever/Chills/Sweats	YES NO	Problems sleeping	YES NO
Unusual fatigue	YES NO	Weakness	YES NO	Joint/Muscle swelling	YES NO
Dizziness/vertigo	YES NO	Blurred/Double vision	YES NO	Arm/leg swelling	YES NO

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure doing things? YES NO

Have you had any of the following tests in the past 12 months?

X-rays/MRI/CT scans YES NO Lab tests: Blood YES NO Urinalysis YES NO

Have you had any surgery, surgical procedures, or injections? If so, please list type and approximate date:

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