Holy Name Medical Center

718 Teaneck Road
Teaneck, NJ 07666

MEDICAL HISTORY / SUBJECTIVE INFORMATION

Name _____ Date ___/___/___ Age _____

Who referred you to our center? _____ Primary Language _____

The best number to contact me at (___) _____ In case of emergency call _____

Do you have any religious, cultural or special needs? _____

Medical History: ***(please check all that apply)***

☐ Heart Disease ☐ Cancer ☐ HIV/AIDS ☐ Stroke/CVA/TIA ☐ High Blood Pressure ☐ Diabetes ☐ Tuberculosis
☐ Arthritis ☐ Asthma ☐ Visual Impairment ☐ Osteoporosis ☐ Hepatitis ☐ Epilepsy ☐ Fibromyalgia ☐ MS
☐ Hearing Impairment ☐ Pacemaker ☐ Scoliosis ☐ Are you Pregnant? ☐ Are you a Smoker?
☐ Other (including any allergies): _____

Past Surgical History: _____

Please list all medications that you are taking (including any over the counter and herbal supplements):

_____

What are your current symptoms? ☐ Pain ☐ Numbness ☐ Weakness ☐ Loss of movement ☐ Disrupted sleep
☐ Nausea ☐ Fatigue ☐ Dizziness ☐ Swelling ☐ Difficulty walking ☐ Other _____

When did the injury or symptoms occur? _____

How did the injury or problem occur? _____

Have you ever had any of the following for your condition?	Yes	No	If yes, please give approximate date(s)
Diagnostic tests (x-ray, MRI, etc.)	☐	☐	_____
Surgery	☐	☐	_____
Injections (cortisone, etc.)	☐	☐	_____
Previous therapy	☐	☐	_____

Pain: Please rate your pain scale using a 0-10 scale
(0 = no pain, 10 = the worst pain you can imagine)

Worst pain since onset: 0 1 2 3 4 5 6 7 8 9 10
Best pain since onset: 0 1 2 3 4 5 6 7 8 9 10
Today's pain: 0 1 2 3 4 5 6 7 8 9 10

Describe your pain (check all that apply):
☐ Aching ☐ Burning ☐ Throbbing ☐ Pulling ☐ Sharp
☐ Dull ☐ Pricking ☐ Tingling ☐ Numb ☐ Pressing

Is your pain: ☐ Constant ☐ Intermittent/ comes and goes

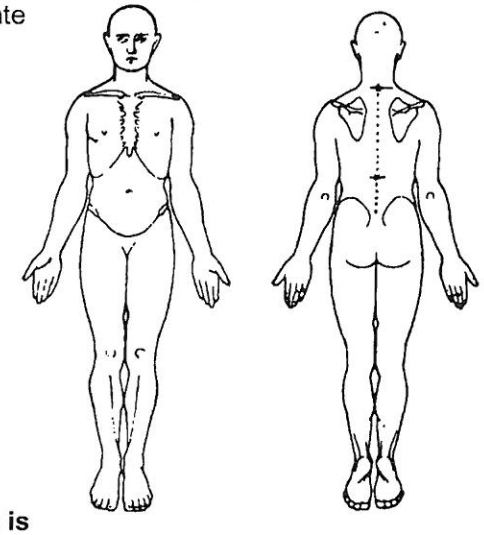
What makes your pain/ problem
better: _____
worse: _____

Is there pain present at night? ☐ Yes ☐ No

What are your goals in therapy? _____

_____

Where is your pain or problem located? Please indicate on picture.



To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services at Holy Name Medical Center.

Patient Signature _____ **Date** _____ **Time** _____

THIS SECTION IS FOR THERAPIST USE ONLY

Additional comments/follow-up required _____

_____

_____

Therapist Signature _____ Date _____ Time _____