MemorialCare™
Orange Coast Medical Center

Patient Medical Information/Problem Sheet

I.	Existing Medical Conditions	Medications Prescribed	Treating MD	Therapist Initials
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____

II. List previous injuries/surgeries/hospitalizations and dates of occurrence **Therapist Initials**

_____ Date:_____ _____
_____ Date:_____ _____
_____ Date:_____ _____
_____ Date:_____ _____
_____ Date:_____ _____

III. Allergies/Adverse Drug Reactions: **Therapist Initials**

_____ _____ _____ _____

IV. Other related conditions

Check all that apply if you have had a history of:

☐ Seizures
☐ Diabetes
☐ Cardiac disease
☐ Rheumatoid arthritis
☐ Osteoarthritis
☐ Osteoporosis
☐ High Blood Pressure
☐ Bowel/Bladder changes
☐ Unexplained weight loss
☐ Asthma/Respiratory Disorders
☐ Metal implants
☐ Smoking
☐ Other:_____

☐ Thyroid problems
☐ Stroke/CVA
☐ Cancer
☐ Heart Attack
☐ Current pregnancy
☐ Recent flu/fever
☐ Pacemaker
☐ Chronic headaches
☐ Liver/kidney problem
☐ Nervous disorder
☐ Bone disease/fractures
☐ Hernia

☐ Joint Replacement
☐ Depression
☐ Glaucoma
☐ Swallowing Problems
☐ Recent falls
☐ Anemia
☐ Dizziness
☐ Vascular/Circulatory disease

I hereby certify that I am taking only the medications listed.
Signature: _____

TURN OVER

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PATIENT INFORMATION

Name:_____ Date:_____
Occupation:_____ Job Duties:_____
Leisure Activities:_____ Age: _____

Please answer each question concisely:

What date did the problem start?_____

Was it due to an *injury* or a *surgery* (please circle one)

What is your major complaint?_____

Briefly state previous treatment, if any:_____

Do you have numbness and/or tingling?_____ Where?_____

Rate your overall daily pain: **(*No pain=0*)** 0 1 2 3 4 5 6 7 8 9 10 ***(10=worst possible pain)***

Does your pain interrupt your sleep? YES_____ NO_____

If yes, do you easily return to sleep? YES_____ NO_____

What is your pain like in the morning?_____

What is your pain like in the evening?_____

What makes your pain/symptoms worse?_____

What makes your pain/symptoms better?_____

Are you taking medications for this problem? YES_____ NO_____
If yes, please list:_____

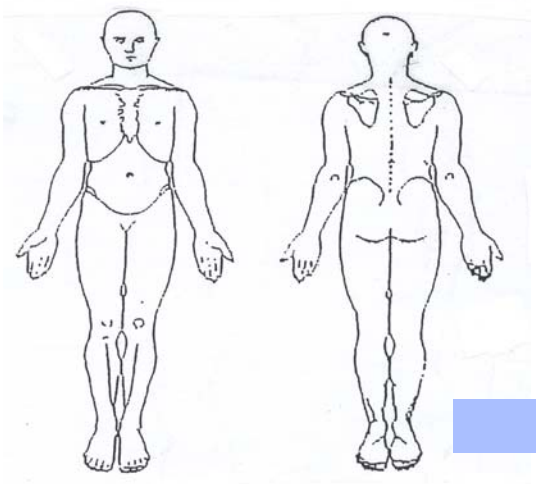
Have you had any X-rays, CAT scans, MRIs or other diagnostic tests for your disorder?

YES (please list): _____ NO_____

What are your goals for therapy? _____

_____

PLEASE DARKEN IN THE AREAS OF YOUR PAIN/SYMPTOMS ON THE BODY CHART



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