

JOINT EFFORT REHAB LLC MEDICAL HISTORY

A complete medical history is necessary for a thorough evaluation. Please answer the following questions:

| | | | | | | |
|----------------|------|---------|---------|----------------|-------|-------------|
| Your Name: | | | | | Date: | |
| Date of Birth: | Age: | Height: | Weight: | Do you Smoke?: | | No Yes |

Have you ever been diagnosed with any of the following?

| | | | | | |
|------------------------------|----|-----|--------------------------------|----|-----|
| Tuberculosis | No | Yes | Congestive Heart Failure (CHF) | No | Yes |
| Hepatitis | No | Yes | High Blood Pressure | No | Yes |
| Diabetes | No | Yes | Heart Attack (MI) | No | Yes |
| Stroke | No | Yes | Atherosclerotic Disease (CAD) | No | Yes |
| Chronic Respiratory Problems | No | Yes | Angioplasty | No | Yes |
| Epilepsy | No | Yes | Valvular Disease | No | Yes |
| Arthritis | No | Yes | Stents | No | Yes |
| Cancer | No | Yes | Arrhythmia | No | Yes |
| Osteoporosis / Osteopenia | No | Yes | Coronary Artery Bypass (CABG) | No | Yes |
| Closed Head Injury | No | Yes | Angina | No | Yes |
| Are you currently pregnant? | No | Yes | Pacemaker | No | Yes |

Have you received any injections for your injury or condition? No Yes

If yes, what kind and when? _____

Did it help? No Yes

Are you exercising? No Yes Describe _____

Problems with exercise? No Yes Describe _____

What do you hope to accomplish with therapy? _____

Significant past or present medical diagnoses and chronic conditions not listed above:

| Diagnosis | Physician | Medications |
|-----------|-----------|-------------|
| | | |
| | | |
| | | |
| | | |

Is there any other pertinent information you would like us to know about your condition?

Patient or Responsible Party: _____ Date: _____