MiraSol Physical Rehab Center
Desire.Sante LLC

Patient Name: _____ Date: _____
Referring Physician: _____ Primary Physician:_____
Date of First Doctor Visit For This Injury/Condition: _____
Are you aware of your diagnosis and prognosis as explained by your doctor? ___Yes ___No
Date of Onset of Symptoms/Injury:_____ Injury Type: ___Auto ___Work Related ___Other _____
Describe Injury: _____
Last Date Worked due to Injury/Condition: _____ Date Returned to work after this Injury/Condition: _____
Have you been hospitalized recently: ___Yes ___No If yes, dates of hospitalization: _____
Have you had surgery for this injury/condition: ___Yes ___No Number of surgeries: _____
Type of Surgery: _____ Dates of Surgery: _____
Are you currently taking any prescription or non prescription medications? ___Yes ___No
Anti Inflammatory: _____Muscle Relaxants: _____Pain Medication: _____
List Medications: 1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____
___ See attached list
Are you allergic to any medications: ___Yes ___ No known allergies
List Medication (s) allergic to: _____

Have you had any of the following Medical or Rehabilitative Services for this injury/episode: check all that apply

___Chiropractor ___Podiatrist ___Occupational Therapy ___Speech Therapy
___General Practitioner ___ Orthopedic Surgeon ___ Massage Therapy ___ X-ray
___Neurologist ___Physical Therapy ___MRI and/or CTScan
___ Other, please specify: _____

Do you or have you ever had ANY of the following? Check all that apply

___Any pins or metal implants ___Sleeping problems/difficulties ___ Depression/Anxiety
___Asthma, Bronchitis, or Emphysema ___ Severe or frequent headaches ___ Neck injury/surgery
___ Cancer or Chemotherapy/Radiation ___ Knee Injury/Surgery ___ Shortness of Breath/chest pain
___Elbow/hand Injury/Surgery ___Diabetes ___ Arthritis
___Epilepsy/Seizures ___Shoulder Injury/Surgery ___Back Injury/Surgery
___Osteoporosis ___TB Tuberculosis ___Infectious Disease
___Pacemaker ___ Dizziness or fainting ___Numbness/Tingling
___Stroke/TIA ___Leg/Ankle/Foot Injury/Surgery ___High Blood Pressure
___Urinary Incontinence ___ Heart Attack or Heart Surgery ___Congestive Heart Failure
___ Vision or Hearing Difficulties ___Heart Disease or Angina ___Joint Replacement Surgery
___TBI/Head injury

Do you have DIFFICULTY with any of the following? Check all that apply ___Other:_____

___Hearing ___Speech ___Vision ___Following Directions ___Writing ___Other:_____

How do you best learn?

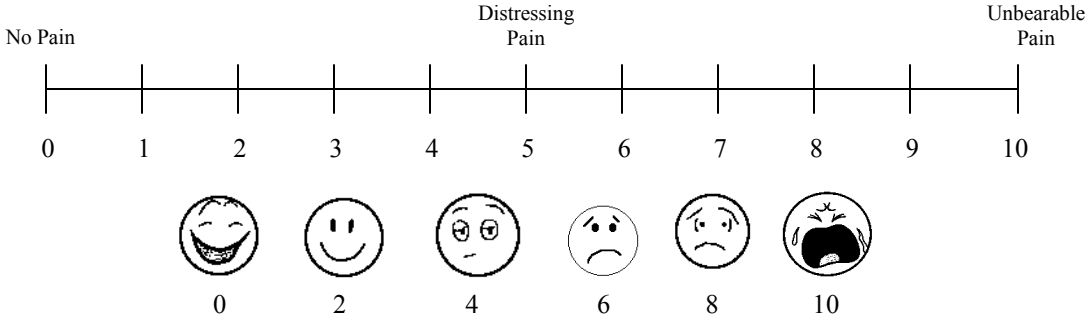
___Reading ___Verbal ___Observation ___Hands-on Demonstration ___Other_____

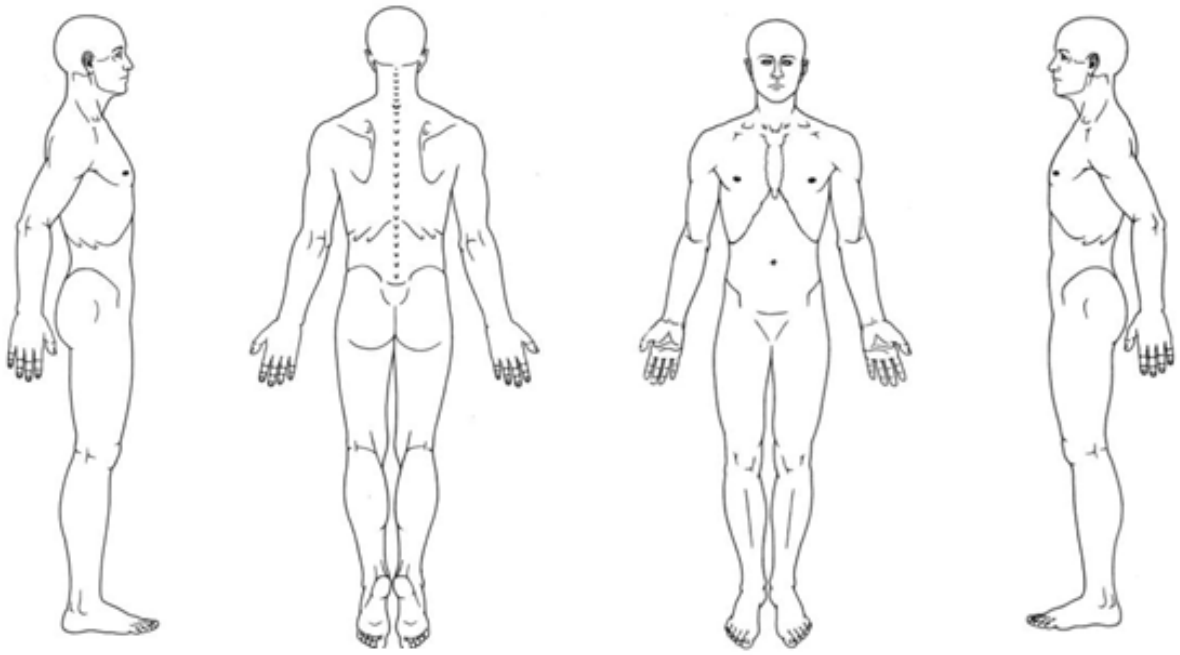
For patients under 18 years of age:

Does the patient's current immunization status meet the school system requirements? ___Yes ___No
Do you have any religious or cultural practices we need to be aware of when providing care? ___Yes ___No

Patient Name: _____ Date: _____

Instructions: Please indicate where you are having pain by <u>writing down a number based on the scale below on the corresponding body part.</u>





1) What activities <u>increase</u> your pain?

_____

2) What activities <u>decrease</u> your pain?

_____

3) How much time is pain present? Check one.

___75-100%
___ 50-75%
___25-50%
___0-25%

4) Do you have any loss of feeling? ___Yes ___No

5) Is the loss of feeling ___Constant ___Intermittent?