Elmhurst Memorial
Healthcare
Elmhurst, Illinois 60126

# REHAB - Outpatient Medical History

To assist your therapist in providing the optimal rehabilitative program, please complete the following:

**Please check if you currently have, or have ever had, any of the following:**

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease/Attack
- ☐ Pacemaker, TENS, Spinal Stimulator
- ☐ Chronic Headaches
- ☐ Kidney Problems
- ☐ Nervous Disorder
- ☐ Hernia (list type ______________)
- ☐ Allergy to Heat
- ☐ Allergy to Cold
- ☐ Stroke
- ☐ Emphysema
- ☐ Bowel/Bladder Problems

- ☐ Allergy to Latex
- ☐ Allergy to Medicine
- ☐ Other Allergies
- ☐ Metal Implants, Pins, Plates, Shrapnel
- ☐ Seizures
- ☐ Dizziness
- ☐ Cancer
- ☐ Pregnant
- ☐ Previous Therapy
- ☐ Previous Surgery
- ☐ Bronchitis
- ☐ Asthma
- ☐ Osteoporosis

Therapist's Comments:

______________________________
______________________________
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______________________________
______________________________

Please list any tests performed for this condition: ______________________________

Are you presently working? ☐ Yes ☐ No ☐ Light duty ☐ Retired

What is your occupation? ______________________________

Please check if you have recently experienced: ☐ Fever ☐ Weight loss ☐ Loss of appetite

What is your chief complaint?______________________________

Onset date for current complaint/injury: Month ________ Year ________

What is your goal for therapy? ______________________________

Preferred learning style (please check):

☐ Visual ☐ Verbal ☐ Demonstration ☐ Written ☐ Other ______________

I verify that the above information is true and accurate to the best of my knowledge.

______________________________ / /______
Patient/Guardian Signature Date

ALLERGIES:*** SEE EMR FOR ALLERGIES ***

I have reviewed the above information with patient.

______________________________ / /______
Therapist's Signature Date