Michigan Abilities Center PM&R Client History Form

Name: _____ Date: _____

Contact Phone Number: _____ Age: _____ Date of Birth: _____

Family Doctor/Internist:
Name: _____
Phone number: _____
Fax number: _____
Send them a letter? Yes No

Who referred you to us?
Name: _____
Phone number: _____
Fax number: _____
Send them a letter? Yes No

Diagnostic Testing: ___MRI ___CT ___X-Ray ___Myelogram ___Bone Scan ___EMG/NCS

Are you employed? ____Yes _____No Occupation_____

Reason for Visit:_____
_____
_____

How long have you had your problem? _____Years _____ Months _____Weeks

Describe your problem: Date of onset (or date of injury):_____
_____
_____ _____
_____

Circle the number on the line best describing your current amount of pain:

0 1 2 3 4 5 6 7 8 9 10
No pain moderate severe

Past Medical History: Please check all that apply to you.

	Diabetes		Stroke		Thyroid Disease
	Heart Disease		Kidney Disease		Stomach Ulcers
	High Blood Pressure		Liver Disease		Reflux (GERD)
	Asthma/Lung Disease		High Cholesterol		Cancer
	Neck Pain		Back Pain		Depression/Anxiety

Others please list:
_____
_____

Past Surgical History: (None ___)
_____
_____
_____

Current Medications (with dosages):
_____
_____
_____

Allergies: (None ___)

_____

_____

Social History:

Tobacco: Yes No _____ packs per day for _____ years
Alcohol Use: Yes No How much? _____
Illicit Drug Use: Yes No _____
Occupation/Hobbies: _____
Right or Left hand dominant:_____Marital Status: _____ Lives with_____
Use cane, walker, wheelchair or brace_____

Review of Systems:
Please circle **Yes** or **No** if you have any of the following problems?

Constitutional			**Genitourinary – cont'd**			**Eyes**		
Good General Health	Yes	No	Pregnant	Yes	No	Wear Glasses/Contacts	Yes	No
Unexplained Weight	Yes	No	Change in Bladder	Yes	No	Blurred/Double Vision	Yes	No
Night Sweats/Fevers	Yes	No	Menstrual Problems	Yes	No	Eye Disease or Injury	Yes	No
Chills/Fevers	Yes	No				Glaucoma	Yes	No
Cardiovascular			**Respiratory**			**Gastrointestinal**		
Chest Pain	Yes	No	Shortness of Breath	Yes	No	Nausea/Vomiting	Yes	No
Palpitations	Yes	No	Cough	Yes	No	Abdominal pain	Yes	No
Heart Trouble	Yes	No	Wheezing/Asthma	Yes	No	Rectal Bleeding	Yes	No
Swelling Hands/Feet	Yes	No	Coughing up Blood	Yes	No	Bowel Problems	Yes	No
Musculoskeletal			**Neurological**			**Integumentary (Skin)**		
Muscle Pain or Cramps	Yes	No	Frequent Headaches	Yes	No	Change in Hair or Nails	Yes	No
Stiffness/Swelling Joints	Yes	No	Paralysis or Tremors	Yes	No	Rashes or Itching	Yes	No
Joint Pain	Yes	No	Convulsions/Seizures	Yes	No	Mouth Sores	Yes	No
Trouble Walking	Yes	No	Numbness Tingling	Yes	No	Easily Bleed	Yes	No
Endocrine			**Hematologic/Lymphatic**			**Allergic/Immunologic**		
Excessive Thirst	Yes	No	Bruise Easily	Yes	No	Food Allergies	Yes	No
Excessive Urination	Yes	No	Slow to Heal	Yes	No	Aspirin Allergies	Yes	No
Thyroid Disease	Yes	No	Enlarged Glands	Yes	No	Antibiotic Allergies	Yes	No
Hormone Problems	Yes	No						
			Psychiatric			**Ears/None/Mouth/**		
Genitourinary			Insomnia	Yes	No	**Throat**		
Blood in Urine	Yes	No	Confusion/Memory Loss	Yes	No	Hearing Loss or Ringing	Yes	No
Kidney Stones	Yes	No	Depression	Yes	No	Sinus Problems	Yes	No
Sexual Problems	Yes	No	Life Stress Issues	Yes	No	Nosebleeds	Yes	No
Testicle Pain	Yes	No				Sore Throat/Voice change	Yes	No

Additional concerns:

_____

_____

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Signed: _____ Date: _____
Signature of Client / Responsible Party (guardian or parent if under 18 years old)

For Office Use Only:
Physician Statement: I have reviewed the questionnaire with the patient

Signed: ____ Date: ______________________