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Beyond Limits Rehabilitation – Medical History/Questionnaire **Today's Date_____**

To be completed by the patient or guardian – Please Print

Name: _____ D.O.B. _____ Sex: _____

Driver's License: _____ SSN: _____ Email: _____

Home Phone: _____ Cell: _____

Address: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Employer: _____ Phone: _____

Referring Physician: _____ Date of next physician's visit: _____

Chief Complaints: (What problems are you having?)

_____

_____

_____

Date of injury/when pain started? _____ Date of surgery (if applicable): _____

Have you had physical therapy of chiropractic treatment this year? Y N If yes, where: _____

Do you smoke? Y N If so, how many packs /day? ____

Do you drink alcohol? Y N How much? _____

Do you regularly exercise? Y N

Do you have any drug allergies: Y N Please specify _____

Please list your current medications: If additional space is needed, please use reverse side of page

Name of Medication	Dosage	Directions	Date Stopped	Reason/Doctor who prescribed

Have you ever had the following (circle yes or no, leave blank if uncertain)

Anemia	**Y N**	**Dizziness or Fainting Spells**	**Y N**	**Pacemaker**	**Y N**
Arteriosclerosis	**Y N**	**Epilepsy**	**Y N**	**Phlebitis**	**Y N**
Arthritis	**Y N**	**Gastrointestinal problems**	**Y N**	**Pneumonia/Respiratory problems**	**Y N**
Asthma/Emphysema	**Y N**	**Heart Disease**	**Y N**	**Pregnant currently**	**Y N**
Back/Neck Trouble	**Y N**	**Hernia**	**Y N**	**Skin Disease/Rashes**	**Y N**
Bleeding Tendency	**Y N**	**High or Low Blood Pressure**	**Y N**	**Stroke**	**Y N**
Blood Clots	**Y N**	**Incontinence**	**Y N**	**Thyroid Disease**	**Y N**
Cancer	**Y N**	**Kidney Disease**	**Y N**		
Circulatory Condition	**Y N**	**Metal Implants**	**Y N**		
Depression	**Y N**	**Migraines**	**Y N**		
Diabetes	**Y N**	**Mitral Valve Prolapse**	**Y N**		

If you answered yes to any of the items above, please briefly explain and give the date. Include pertinent information regarding your past medical history:

_____

_____

_____

_____

Previous Surgeries (Please state year and what illness/surgery you had)

Date/Year	**Illness/Operation**	**Date/Year**	**Illness/Operation**

_____

_____

_____

_____ I authorize Beyond Limits Rehabilitation to render appropriate evaluation and therapy services in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time in writing. In addition, Beyond Limits Rehabilitation may terminate services by notifying me in writing.

_____ _____

Patient Name (Please print) **Date**

_____ _____

Patient/Guardian Signature **Date**