Morton Hospital
A STEWARD FAMILY HOSPITAL
Outpatient Rehabilitation Department
705 Bay Street, Taunton, MA 02780
Phone: (508) 828-7265 Fax: (508) 828-7264

Name:_____
MR#:_____
D.O.B.:____/____/____
Referring MD:_____

Medical History

Date of Birth: _____ Age: _____ Height:_____ Weight:_____
Job Title:_____ Employer:_____

Current Problem you are seeking therapy for?:_____
_____
When did the injury occur?:_____
How did the injury occur?:_____
Diagnostic tests done (X-ray, MRI, etc.)? Yes No If yes, what?:_____
List the activities that are difficult for you because of your injury:_____
_____
_____

Please circle your current pain level: 0 1 2 3 4 5 6 7 8 9 10 (0=no pain, 10=worst pain)
Acceptable pain level: 0 1 2 3 4 5 6 7 8 9 10 (What level of pain can you function with?)

(* Indicate potential for falls risk)
Have you ever been diagnosed with any of the following: (please circle all that apply)

CARDIOVASULAR:			PULMONARY:		
High Blood Pressure	Y	N	Tuberculosis	Y	N
Low Blood Pressure*	Y	N	COPD	Y	N
Heart Attack	Y	N	Asthma	Y	N
Stroke*	Y	N	Chronic Bronchitis	Y	N
Bleeding Disorder	Y	N	Emphysema	Y	N
Congestive Heart Failure	Y	N	Other (please specify)		
Pacemaker	Y	N			
Other_____					
			SYSTEMIC:		
NEUROLOGICAL:			Diabetes	Y	N
Vertigo*	Y	N	Cancer	Y	N
Seizures*	Y	N	Rheumatoid Arthritis	Y	N
Ataxia	Y	N	Hernia	Y	N
Parkinson's*	Y	N	Hepatitis	Y	N
Numbness/Tingling*	Y	N	Other (please specify)		
If yes, where:_____			_____		
Balance issues *	Y	N			
Dizziness*	Y	N	MUSCULOSKELETAL:		
Fainting*	Y	N	Osteoporosis	Y	N
Other (please specify)			Osteoarthritis	Y	N
_____			Degenerative Joint Disease	Y	N
			Fibromyalgia	Y	N
ARE YOU PREGNANT	Y	N	Other (please specify)		

Name:_____

MR#:_____

Do you have uncorrected vision or hearing problems?* Y N

Do you use glasses?* Y N Do you use hearing aids?* Y N

Have you fallen in the last 6 months?* Y N

Do you use an assistive device for ambulation (i.e. crutches, cane, walker)?* Y N

Any history of surgeries? Y N If yes, what/when_____

_____

Medication*: (please list any and all medications you are currently taking. This includes vitamins and supplements)

MEDS/OTCs/HERBALS	DOSAGE	FREQ	DATE

Please List Any Allergies:

Personal Goal you wish to achieve with therapy:_____

_____

Please circle your preferred learning style: Verbal Written Demonstration

_____ _____

Person completing this form PT/OT reviewing this form

_____ _____

Relationship to the Patient Date/Time