**Marsh Brook Rehab** Acct #:_____ Date:_____ Reviewed with Pt

**Have you had Physical/Occupational Therapy at another facility this year? _____ Yes _____ No**

**Approximately how many visits _____ or what months _____**

Patient Name (Please Print):_____

Telephone # (Home/Cell):_____

**Emergency Contact Person: _____ Tel #:_____Relationship:_____**

Diagnosis:_____ Primary Care MD/ Tel#:_____

## Health Information

| Health Conditions | Yes | No | Treatment/Condition/Date |
|---|---|---|---|
| Lung Disease | | | |
| Liver Disease (Hepatitis) | | | |
| Kidney Disease | | | |
| Heart/Cardiac Disease | | | |
| Diabetes (Type) | | | |
| High/Low Blood Pressure | | | |
| Arthritis | | | |
| Blood Clots/Circulation Problem | | | |
| Mental Health (Ex. Anxiety, Depression) | | | |
| Seizures/Epilepsy/Fainting (syncope) | | | |
| Weight Loss or Gain | | | |
| Cancer: Location_____ | | | |
| Tuberculosis | | | |
| Bruise Easily (Anemia, Meds) | | | |
| Multiple Sclerosis | | | |
| Thyroid Disease | | | |
| Stroke | | | |
| Osteoporosis/Osteopenia | | | |
| Recent Falls | | | |
| Contagious Disease (Ex MRSA, C-Diff, HIV) | | | |
| Neurological/Cognitive Impairments | | | |
| Hearing/Vision Impairments | | | |

Other Medical Conditions:_____

Precautions (i.e. Pacemaker, THR):_____

Current Medications (Include Herbs and Vitamins):_____

_____

Past Surgeries and Date (Orthopedic, Cardiac, etc): _____

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Recent Hospitalization (Reason and Date):_____

Allergies:_____

Height:_____ Weight:_____ Age:_____ DOB:_____

Do you smoke, and how many packs per week: _____ Do you drink, how many per week: _____

Women: Are you Currently Pregnant? Yes___ No___

Marital Status: Single____ Married___ Widowed___ Divorced___

Occupation: _____