PAST MEDICAL HISTORY & CONSENT FORM

Date: ___________________________ Birthdate: ___________________________

Date of onset of symptoms: ___________________________

Date of next physician’s visit: ___________________________

Have you ever had these symptoms before?  □ Yes  □ No

Have you ever had treatment for this problem before?  □ Yes  □ No
If so, What? _______________________________________

My symptoms are currently:  □ getting better  □ getting worse  □ staying the same

What do you think caused your symptoms: ___________________________

What makes your symptoms better: ___________________________

What makes your symptoms worse: ___________________________

Are you currently on any medical restrictions?  
If so, what are they? _______________________________________

Is this a work related injury:  □ Yes  □ No

On the scale below, please circle the number which best represents the severity of your pain on average:

No Pain  0  1  2  3  4  5  6  7  8  9  10  Worst Pain Imaginable

Have you RECENTLY noted any of the following (check all that apply):

Fatigue  □  Weight Gain or Loss  □  Heartburn / Indigestion
Fever / Chills / Sweats □  Numbness / Tingling □  Change in Appetite
Nausea / Vomiting □  Dizziness / Lightheadedness □  Bowel / Bladder Changes
Poor Balance / Falls □  Vision Changes □  Difficulty Swallowing
Increased Pain at Night □  Shortness of Breath □  Muscle Weakness
Headaches □  Cough □  Fainting

Past and Present History:

Cancer □  Chest Pain / Angina □  Allergies (tape, meds, latex)
Heart Problems / Disease □  Liver Disease □  Rheumatoid Arthritis / Osteoarthritis
High Blood Pressure □  Skin Abnormalities / Open Wounds □  Thyroid Disorders
Stroke □  Diabetes / Hypoglycemia □  Osteoporosis
Recent Illness / Hospitalization □  Special Diet Guidelines □  Kidney Disease
Seizures □  Smoking □  Ulcers / Hernia
Blood Clots □  Pacemaker / Defibrillator □  Prolonged Steroid Use
Asthma / Lung Problems □  Depression / Anxiety □  Fractures

If you checked any of the above, or have a condition that is not listed above, please briefly explain and give approximate date:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
### Past Medical History & Consent Form

**Past Surgeries (please list all and date):**

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Have you had an X-Ray, MRI or other imaging study? Do you know the result?**

<table>
<thead>
<tr>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please list current medications and reason for taking them:**

1. **Medication 1** — **Reason 1**
2. **Medication 2** — **Reason 2**
3. **Medication 3** — **Reason 3**

**DURING THE PAST MONTH, HAVE YOU BEEN:**

- Bothered by feeling down, depressed, or hopeless?  
  - Yes  
  - No
- Bothered by having little interest or pleasure in doing things?  
  - Yes  
  - No
- Is this something with which you would like help?  
  - Yes  
  - Yes, but not today  
  - No

Are you taking blood thinners?  
- Yes  
- No

**For Women:** Are you currently pregnant?  
- Yes  
- No  
If yes, expected due date: ________________

List 3 important activities that you are unable to do or having difficulty with as a result of your problem:

1. **Activity 1**
2. **Activity 2**
3. **Activity 3**

**Responsible Practitioner’s Certification.** I hereby certify that I have explained the nature, purpose, benefits, complications from, risks of, alternatives (including no treatment and attendant risks), likelihood of achieving goals of care and potential problems that might occur during recuperation, to the proposed procedure/operation, have offered to answer any questions and have fully answered all such questions. I believe that the patient/agent/relative/guardian fully understands what I have explained and answered. I certify that the procedure described in the permission section of this form is accurate.

**ALMH Rehab Attendance Policy**

In order to better serve our patients, we request that you call to cancel an appointment at least one hour prior to your scheduled appointment time. We reserve the right to discontinue your rehab, cancel all further appointments, and notify your physician if you miss more than 3 appointments. Workers’ compensation patients are expected to attend therapy just as they are expected to attend their job. Missed appointments will be reported to physicians and employers.

**In Case of an Emergency Contact:**

<table>
<thead>
<tr>
<th><strong>Phone Number:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________</td>
</tr>
</tbody>
</table>

**Patient Signature**  
**Date**  
**Signature of Guardian if patient is a minor**  
**Date**

**Therapist Signature**  
**Date**

ALMH Rehabilitation/ Consent/PMHx form 1/29/2018