Bethlehem Rehabilitation Specialists
MEDICAL INTAKE

Patient Name: _____Age: _____ Date: _____

1. What is your main complaint today? _____

Date of injury/onset? _____ ◯SUDDEN ◯GRADUAL

How did it happen? _____

If you are a New Patient, how did you hear about our facility? Please select

Family Friend Advertisement Insurance Doctor Internet Other:_____

2. Have you had similar symptoms before? ◯YES ◯NO (Explain): _____

_____

3. Prior to this episode were you completely symptom free? ◯YES ◯NO (Explain):_____

_____

4. Did this injury occur at work? ◯YES ◯NO (Explain) _____

_____

5. Is this related to a motor vehicle accident? ◯YES ◯NO Date of accident:_____

Did you go to the Emergency Room? ◯YES ◯NO

Were you taken by: ◯Ambulance ◯Family / Friend ◯Self

Did you lose consciousness? ◯YES ◯NO

Were you: ◯Driver ◯Passenger ◯Wearing seatbelt

Check all Diagnostic Tests and Consultations for this Problem:				
TEST		**DATE**	**BODY PART**	**LOCATION/FACILITY**
☐	XRAY			
☐	MRI			
☐	CAT SCAN			
☐	BONE SCAN			
☐	EMG			
☐	OTHER_____			
☐	INJECTIONS			

Check all providers whom you have seen for this problem:					
☐	PHYSICIAN	☐	CHIROPRACTOR	☐	ACUPUNCTURE
☐	DENTIST	☐	PHYSICAL THERAPIST	☐	MASSAGE THERAPY

Date of last wellness/complete physical exam: _____

Do you own/use any of the following: (check all that apply)							
☐	CANE	☐	WHEELED WALKER	☐	WHEELCHAIR	☐	CRUTCHES
☐	WALKER	☐	QUAD CANE	☐	ELECTRIC SCOOTER		

Do you have access to a 1st floor bathroom? ◯YES ◯NO	Do you have stairs to navigate in home? ◯YES ◯NO	Handrails? ◯YES ◯NO

Patient Signature:_____Date:_____

Bethlehem Rehabilitation Specialists
MEDICAL HISTORY

(PRINT) Patient name:_____Birthdate:_____

If you are a new patient please complete both sides.
If you were a prior patient, please **review** both sides and **initial** and **date** any changes.

General Medical History

- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Neuromuscular disease_____
- ☐ Metal implants_____
- ☐ Osteoporosis/Osteopenia
- ☐ Fibromyalgia

- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Asthma
- ☐ COPD / emphysema
- ☐ History DVT / Pulmonary embolism
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease_____
- ☐ Peripheral vascular disease
- ☐ Peripheral neuropathy

- ☐ Cancer (type:) _____
- ☐ Depression
- ☐ HIV/AIDS
- ☐ Alcohol / drug addictions
- ☐ Other_____

Surgical / Medical History — Date

- ☐ Fracture with surgery _____ _____
- ☐ Fracture without surgery_____ _____
- ☐ Orthopedic surgeries _____ _____
- ☐ Cardiac surgeries_____ _____
- ☐ Other surgeries_____ _____
- ☐ C-section _____
- ☐ Hernia Repair _____
- ☐ Gastric bypass _____
- ☐ **Injuries** (dislocations, sprains)_____ _____

Social / Occupational History

Hand dominance? ◯ Right handed ◯ Left handed
Do you smoke cigarettes? ◯ Yes ◯ No Previous smoker? If yes, quit date: _____
If yes, packs per day? _____ Number of years?_____

Job title/occupation (if not working now, what was your occupation):_____
Please check current work status: ◯ Full-time ◯ Part-time ◯ Restricted Duty ◯ Homemaker ◯ Retired ◯ Disabled
Recreational Activities:_____

(Please continue to the next side)

Bethlehem Rehabilitation Specialists
REVIEW OF SYSTEMS

(PRINT) Patient name:_____Birthdate:_____

General
- ☐ Fatigue
- ☐ Weakness
- ☐ Trouble sleeping

Skin
- ☐ Rashes
- ☐ Dryness
- ☐ Color changes
- ☐ Hair/nail changes

Head
- ☐ Headache
- ☐ Head Injury

Eyes/Ears/Nose/Throat
- ☐ Blurry or double vision
- ☐ Eye pain
- ☐ Blindness
- ☐ Ear pain
- ☐ Ringing in ears
- ☐ Deafness
- ☐ Nose bleeds
- ☐ Dry mouth
- ☐ Sore throat/hoarseness
- ☐ Non-healing sores

Neck
- ☐ Stiffness
- ☐ Swollen glands
- ☐ Pain

Cardiac
- ☐ Palpitations
- ☐ Chest discomfort at rest
- ☐ Chest discomfort with activity

Circulation
- ☐ Discoloration of feet/legs
- ☐ Sores/ulcers on feet/legs
- ☐ Swelling of ankles/legs
- ☐ Calf pain with walking
- ☐ Leg Cramps
- ☐ Varicose veins

Gastrointestinal
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Unexpected Nausea/vomiting
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Loss of bowel control
- ☐ Abdominal pain

Genitourinary
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Loss of bladder control

Musculoskeletal
- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma

Respiratory
- ☐ Wheezing
- ☐ Shortness of breath with normal activity
- ☐ Shortness of breath with exertion
- ☐ Cough-wet, dry or productive
- ☐ Coughing up blood

Hematology
- ☐ Unexplained fevers
- ☐ Ease of bruising
- ☐ Ease of bleeding

Psychiatric
- ☐ Nervousness
- ☐ Depression
- ☐ Anxiety
- ☐ Memory loss
- ☐ Stress
- ☐ Bipolar Disorder
- ☐ Other psychological diagnosis_____

Metabolism/Endocrine
- ☐ Heat or cold intolerance
- ☐ Excessive sweating
- ☐ Increased thirst
- ☐ Change in appetite
- ☐ Recent unexplained weight changes

Women Only
- ☐ Currently pregnant
- ☐ Breastfeeding
- ☐ Date of last mentrual period ____/___/____

Nervous System
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Numbness/Tingling

Patient Signature	Date	Therapist Signature	Date

Bethlehem Rehabilitation Specialists
PATIENT MEDICATION LIST

(PRINT) Patient name:_____ Birthdate:_____

Please list all prescriptions / vitamins / herbals / over the counter drugs.
(including; pills/capsules, patches, ointments, injections, and those used as needed)

Medications	Dose / Mg	Frequency / Day	Administered			Any Changes?	
			Oral	Topical	Injections	D/C	Please Explain
			☐	☐	☐	☐	
			☐	☐	☐	☐	
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			☐	☐	☐	☐	
****Are you taking Vitamin D?**			◯ **YES**		◯ **NO**	**Therapist √: _____**	

Allergies:_____

Patient Signature	Date	Therapist Signature	Date