JUNCTION REHABILITATION

Junction Rehabilitation
Health History Form

Name: ______________________________	Date of Birth: ____________
Address: ____________________________	Phone: _________________
City: ________________________________	Work: __________________
Postal Code: _________________________	Other: __________________
Occupation: ____	
Email: ____	
Family Doctor or Referring Physician: __________________________________	
How did you hear about us? ____	

It is important that you provide us with an accurate and up-to-date to date health history so that we provide the safest and best care for you. Please inform us immediately of any changes in your health status.

Please tell us what brings you in today_________________________________

When did your symptoms start? ______________________________________

What makes your symptoms worse? ___________________________________

What makes your symptoms better? ___________________________________

Please Mark the severity of your pain on a scale of 0 (least) to 10 (most):

____

0 5 10

Current Medications and What Conditions They Treat:

____

Surgeries/Injuries:

____

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Current Exercise/Activities:

____

Cardiovascular

- ❑ High or low blood pressure
- ❑ Heart attack
- ❑ Stroke/CVA
- ❑ Heart disease
- ❑ Phlebitis
- ❑ Pacemaker or similar device

Respiratory

- ❑ Asthma
- ❑ Emphysema
- ❑ Bronchitis
- ❑ Chronic cough

Infections

- ❑ HIV
- ❑ Tuberculosis
- ❑ Hepatitis
- ❑ Plantar warts

Other

- ❑ Diabetes type ___________
- ❑ Epilepsy
- ❑ Thyroid
- ❑ Irritable bowel
- ❑ Liver/gallbladder
- ❑ Arthritis/rheumatoid
- ❑ Cancer _________________
- ❑ Allergies ________________
- ❑ Pregnancy

By signing below you agree that this is a complete disclosure of your health information and agree to the sharing of your health information between practitioners within this clinic for the purpose of providing the best care for your individual needs.

______________________________ ______________________________

Signature Date