**resolute rehab**

1250 Addison St. Suite 102, Berkeley, cA 94702

P: 510-473-mypt f: 510-443-5092

|  |  |
| --- | --- |
| Confidential information | |
| *Please complete the following as best as possible so I can better serve you.* | |
| Name: (Last, First, MI): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City, State, & Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Home telephone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Work telephone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cell/pager: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Relationship: \_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Partnered \_\_\_\_\_ Divorced \_\_\_\_ Widowed | |
| Spouse/Partner/Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Spouse/Partner/Parent Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Spouse/Partner/Parent Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Spouse/Partner/Parent Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Number of Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Age(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | PCP Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How did you hear about this office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

HEALTH HABITS:

|  |  |
| --- | --- |
| Current Exercise (Type/Frequency): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Tobacco Use (Type/Frequency): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Alcohol Use (Type/Frequency): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Caffeine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other Drugs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Vitamins: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Orthotics: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |
| --- | --- | --- |
| Please list any allergies you have: |  | Current Medications: |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| Please list any surgeries you have had: |  | Any previous treatment for the current problem? |
|  |  |  |
|  |  |  |
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PERSONAL MEDICAL HISTORY

Mark an “X” beside those medical problems you have had or those you now have.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Measles (Rubeola) |  | Tension or Depression |  | Chest Pain |
|  | Rubella |  | Frequent Headaches |  | Chronic Cough |
|  | Mumps |  | Head Injury |  | Palpitations |
|  | Chicken Pox |  | Hay Fever, Asthma |  | High Blood Pressure |
|  | Thyroid |  | Tuberculosis |  | Heart Problems/Defects |
|  | Sinusitis |  | Jaundice, Liver Disease |  | Night Sweats |
|  | Eye Trouble |  | Stomach, GI Trouble |  | Recent Weight Loss/Gain |
|  | Ear Trouble |  | Fainting |  | Neurological Disorder |
|  | Throat Problems |  | Allergies to Drugs |  | Diabetes |
|  | Hypoglycemia |  | Sickle Cell Anemia |  | Hernia |
|  | Joint Problems |  | Pneumonia |  | Numbness/Tingling |
|  | Cancer |  | Seizure Disorder/Epilepsy |  | Currently Pregnant? |
|  | Insomnia |  | Kidney, Bladder Problems |  | Alcohol/Drug Abuse |
|  | Other Sleeping Problems |  | Chemotherapy |  | Difficulty Breathing |

For Women: If pregnant, what trimester: \_\_\_\_\_\_\_\_ Nursing: Y/N Birth Control? If yes, type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Painful Periods: \_\_\_\_\_\_\_ Irregular Cycles?: \_\_\_\_\_\_\_\_\_\_\_\_ Breast Implants/Reductions?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any pertinent family history I should be aware of?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else I should be aware of, or relates to your current complaint?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TODAY’S DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature if Patient Under 18: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Re-check: \_\_\_\_\_\_\_\_ Re-check: \_\_\_\_\_\_\_\_ Re-check: \_\_\_\_\_\_\_\_

Re-check: \_\_\_\_\_\_\_\_ Re-check: \_\_\_\_\_\_\_\_ Re-check: \_\_\_\_\_\_\_\_