



McLEAN REHABILITATION

Patient History

Patient Name: _____

Phone #: _____

Date of Birth: _____

Date: _____

1. Why are you coming to therapy at this time? _____

2. Do you have any physical limitations or restrictions? _____

3. Do you have difficulty or need help with activities of daily living, such as household chores, personal care, work or hobbies? If yes, briefly describe. _____

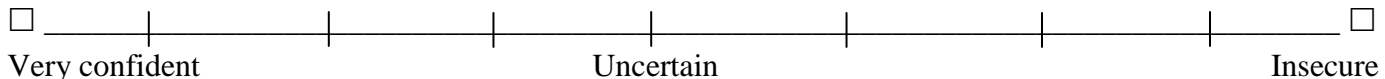
4. Are you working now? Yes No If no or retired, how long have you been out of work? _____

5. What is/was your occupation? _____

- Full time
- Part time
- Light duty
- Retired

6. Do you have pain? Yes No If yes, please indicate where _____

7. Rate how confident you are in your driving skills.



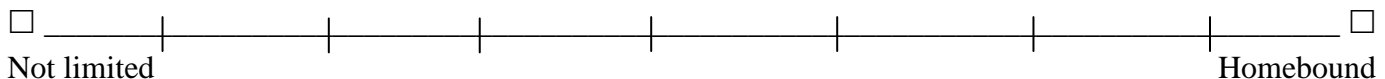
8. In the last six months, have you gotten lost while driving on a familiar route? _____

9. What is your purpose for driving? _____

10. In the last six months, have you been limited in participating in activities outside of your home?

- Yes
- No

Please rate how limited you are in participating in activities outside of your home.



11. Do you have a past or present history of any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Fall with or without injury |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Bladder or bowel problems |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Cancer | <input type="checkbox"/> Metal implants |
| <input type="checkbox"/> Have a pacemaker | <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Prosthetics/orthotics |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Motor vehicle accident(s) |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Dizziness/vertigo | <input type="checkbox"/> Severe sports injuries |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Swallowing problems | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Neurological disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Smoking |

12. Please list prior serious injuries, fractures, surgeries, and hospitalizations (including dates): _____

Name: _____
Date: _____

DOB: _____

13. Please list any allergies you have: _____

14. Please list medications you are taking, if any: _____

15. When is your next doctor appointment? _____ With who? _____

My signature confirms the above information.

Signature: _____ **Date:** _____