RODNEY K. SHOREY
REHABILITATION SERVICES, INC.

MEDICAL HISTORY

PATIENT NAME _____

Present Illness / Condition _____

_____

_____

If pain is a problem, please circle type(s):
Sharp Dull Aching Burning Tingling Numbness Other

Injury / Onset Date _____

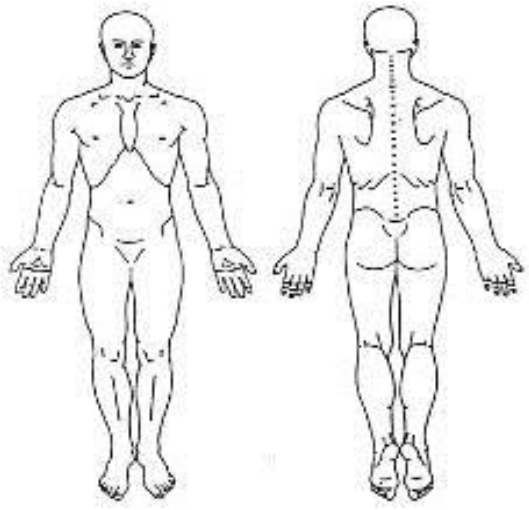
Previous Treatment _____

_____

Has this problem occurred in the past? Yes / No

If yes, please give details _____

_____



Please mark the affected areas

Please circle any of the Conditions you have had or currently have:

Cancer	Leg / Ankle Swelling	Dizziness
Osteoporosis	Circulation Problems / Clots	Asthma / Breathing Problems
Osteoarthritis	Anemia	Kidney Problems
Heart Disease	Peptic Ulcer	Infections
High Blood Pressure	Diabetes	Surgeries
Pacemaker	Loss of Consciousness	Surgical implants

Please explain any circled Conditions _____

_____

Please list any Medical Conditions not listed above _____

_____

Are you currently taking medications? Yes / No

If yes, name / type of Medications _____

Do you smoke? Yes / No

Do you drink alcohol? Yes / No

FEMALES ONLY:

Are you taking birth control pills? Yes / No

Are you pregnant or attempting to become pregnant? Yes / No

If yes, please explain _____

PATIENT / GUARDIAN SIGNATURE _____ DATE _____