THE CENTER FOR REHABILITATION

at BERKSHIRE MEDICAL CENTER

PATIENT HEALTH SUMMARY

Name:

What is your chief problem?

When did your problems (symptoms) start? (Date):

Other past/current medical conditions: (Please check all that apply).

	Diabetes		Angina
	Arthritis		High Blood Pressure
	Cancer		Asthma
	Fractures		Bleeding Disorders
	Back/Neck Injury		Seizures
	Pacemaker		Stroke
	Swallowing		Memory
	Hearing		Incontinence
	Depression		Head Injury
	Fainting/Dizzy Spells		Headaches
	Hepatitis		Infections
	Open Wounds		Tuberculosis
	Smoking		Drinking
	Osteoporosis		Kidney Disease
	Heart Attack		Congestive Heart Failure
	Blood Clots		Thyroid Disorder
	Pregnancy – are you currently or possibly pregnant		
	Other :		

Do you have any allergies or sensitivities to medications, foods, or bee stings, etc?

Medications you are currently taking:

Pertinent tests (i.e. x-rays, MRI, etc.):

Past Hospitalizations and surgeries:

Have you received in the past or are you currently receiving any other treatment for the condition that brings you to us today? ☐ No ☐ Yes, if yes, please list.

Are you currently receiving any home health services (Visiting Nurse)?
☐ No ☐Yes, if yes, please list.

What are your rehabilitation goals? (Check all that apply).

	Increase my activity level
	Get a home exercise program
	Reduce my pain
	Improve my sports performance
	Return to work
	Learn about my problem and how to manage it
	Get a diagnosis and/or prognosis for my condition
	Other:

What are you currently unable to do because of your present condition?

By signing below, you certify that the above information is correct, to the best of your knowledge, and that you have received the rehabilitation orientation pamphlet.

Patient Signature: ______________________________ Date: ___________________