

# REHABILITATION RESOURCES OF MARYLAND, Inc.

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## GENERAL HEALTH REVIEW

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ HANDED: R L RACE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_ Date of last visit \_\_\_\_\_

PRIMARY CARE DOCTOR: \_\_\_\_\_

CHIEF COMPLAINT: \_\_\_\_\_  
\_\_\_\_\_

Have you had any of the following problems or medical conditions?

FEVER, CHILLS OR SWEATS.....	YES/NO	SUBSTANCE ABUSE.....	YES/NO
UNEXPLAINED WEIGHT CHANGE.....	YES/NO	EMOTIONAL ABUSE.....	YES/NO
LOSS OF ENERGY.....	YES/NO	HEART DISEASE.....	YES/NO
NAUSEA OR VOMITING.....	YES/NO	HIGH BLOOD PRESSURE.....	YES/NO
BOWEL DYSFUNCTION.....	YES/NO	CANCER.....	YES/NO
WEAKNESS.....	YES/NO	BLEEDING DISORDERS.....	YES/NO
DIZZINESS OR LIGHT-HEADED.....	YES/NO	THYROID DISEASE.....	YES/NO
NIGHT PAIN.....	YES/NO	DIABETES.....	YES/NO
SHORTNESS OF BREATH.....	YES/NO	RESPIRATORY DISEASE.....	YES/NO
PAIN ON URINATING.....	YES/NO	SEIZURES.....	YES/NO
URINARY FREQUENCY CHANGES.....	YES/NO	ARTHRITIS.....	YES/NO
SEXUAL DYSFUNCTION.....	YES/NO	OSTEOPOROSIS.....	YES/NO
HEADACHES.....	YES/NO	STROKE.....	YES/NO
NUMBNESS.....	YES/NO	PINS & NEEDLES.....	YES/NO
ANGINA/CHEST PAIN.....	YES/NO	ALLERGIES.....	YES/NO
CHANGE OF APPETITE.....	YES/NO	INFECTIOUS DISEASE.....	YES/NO
DEPRESSED.....	YES/NO	UNDER STRESS.....	YES/NO

IF YES, PLEASE COMMENT: \_\_\_\_\_  
\_\_\_\_\_

Do you have any other health issues we should know about? Yes/No Please explain: \_\_\_\_\_  
\_\_\_\_\_

Have you had any recent or major surgeries? Yes/No Please explain: \_\_\_\_\_  
\_\_\_\_\_

**OVER**

### HUNT VALLEY PHYSICAL THERAPY & REHABILITATION

11350 McCormick Road, Suite LL8 • Hunt Valley, MD 21031 • (410) 527-1794 • Fax (410) 527-9467  
www.huntvalleypt.com

### JACKSONVILLE PHYSICAL THERAPY

14307 Jarrettsville Pike • PO Box 186 • Phoenix, MD 21131 • (410) 628-7011 • Fax (410) 628-2305  
www.jacksonvillept.com

NAME: \_\_\_\_\_

Do you smoke? Yes/No Packs/day \_\_\_\_\_ For how long (yrs.) \_\_\_\_\_

Do you drink alcoholic beverages? Yes/No If yes, \_\_\_\_\_/week or \_\_\_\_\_/day

Please list all medications you are taking: \_\_\_\_\_

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

What type of work do you do? \_\_\_\_\_

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

What recreational or fitness activities do you do? \_\_\_\_\_

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

What activities have become limited because of your current problem? \_\_\_\_\_

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

What is your current pain level?

0 1 2 3 4 5 6 7 8 9 10  
No pain Extreme pain

Please describe your pain and mark its location below on figure: \_\_\_\_\_

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

