Rehab Concierge Services, LLC
Rehab and Beyond

MEDICAL HISTORY AND SCREENING FORM

Name _____

Family Physician and/or Primary Health Care Provider:

Doctor/Other_____ Phone _____

Would you like me to send a copy of your consultation to your physician or primary health care provider and consult with them as necessary?

☐ Yes ☐ No

Signature:_____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Sex:

☐ Male ☐ Female

Check those questions to which your answer is yes (leave others blank).

- ☐ High blood pressure
- ☐ Asthma
- ☐ Pacemaker
- ☐ Glaucoma
- ☐ Diseases of the arteries
- ☐ Varicose veins
- ☐ Arthritis (Osteoarthritis/ Rhematoid)
- ☐ Diabetes
- ☐ Phlebitis (inflammation of a vein)
- ☐ Dizziness or fainting spells
- ☐ Epilepsy or seizures
- ☐ Stroke
- ☐ High cholesterol
- ☐ Neuropathy
- ☐ Any numbness or tingling in arms or legs
- ☐ Any implants (breast, surgical, joint replacements) _____
- ☐ Anemia

- ☐ Thyroid problems
- ☐ Other _____

Women only answer the following. Do you have:

- ☐ Menstrual period problems?
- ☐ Significant childbirth - related problems?
- ☐ Urinary leaking with cough, sneeze or laughing?
- ☐ Pelvic surgeries _____

Present Medical History

Pain:

Pain level (1-10) *1-intermittent,dull / 10-Sharp,radiating* _____

Affected area: _____

Circle one as it relates to your pain:

Radiating pain Yes No
Numbness/ Tingling Yes No
Pain with sitting ↑ ↓
Pain with Standing ↑ ↓
Symptoms worse in A.M. P.M.

How long have you had this problem?

Did you have any injuries/accidents in last 3-6 months?

Have you seen any specialist besides, your primary care physician for this problem?

Does anything make it better/worse?