

# Over the Mountain Rehab, Inc.

## Medical History

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City State ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Referring Physician \_\_\_\_\_ Date of Injury or Surgery \_\_\_\_\_

### How did you hear about Over the Mountain Rehab? (Please Check)

\_\_\_\_\_ Physician \_\_\_\_\_ Friend \_\_\_\_\_ Family Member \_\_\_\_\_ Former Patient

### Medications For Current Condition (Please Check)

\_\_\_\_\_ Anti-Inflammatory \_\_\_\_\_ Muscle Relaxers \_\_\_\_\_ Pain Medication

### Do you presently have or have a history of ANY of the following? (Please Check)

_____ High Blood Pressure	_____ Dizziness or Fainting
_____ Heart Attack / Heart Disease	_____ Allergies
_____ Cancer / Chemotherapy/ Radiation	_____ Osteoporosis
_____ Epilepsy / Seizures	_____ Numbness or Tingling
_____ Blood Clot / Emboli	_____ Severe / Frequent Headaches
_____ Diabetes	_____ Bowel or Bladder Problems
_____ Anemia	_____ Any Pins or Metal Implants
_____ Pacemaker	_____ Joint Replacements
_____ Infectious Diseases	_____ Back Injury / Surgery
_____ Arthritis	_____ Knee Injury / Surgery
_____ ARE YOU PREGNANT?	_____ Shoulder Injury / Surgery
	_____ Neck Injury / Surgery

### Current Pain Rating: (Please Circle)

**0**      **1**      **2**      **3**      **4**      **5**      **6**      **7**      **8**      **9**      **10**  
No Pain Requires  
ER Visit

Signature \_\_\_\_\_ Date \_\_\_\_\_