STUART REHAB CLINIC

Rehabilitation Department
312 N. Fremont St., Suite B
Stuart, Iowa 50250
Phone: 515.523.8049
Fax: 641.332.3809

CURRENT PROBLEM: _____

Date of injury or start of condition: _____

What happened? Briefly describe your current problem: _____

_____

Are you receiving Home Health care?	Yes	No
Have you received any Physical Therapy services this year?	Yes	No

MEDICAL HISTORY: Please circle any past or current medical conditions you may have:

Cardiac Heart Failure	Cancer	Stroke
Pacemaker	High Blood Pressure	Head Injury
Heart Disease	Diabetes	Neck and Back Pain
COPD	Gout	Pacemaker
Irregular Heart Rate	Arthritis	Smoking (circle: current or history)

Other _____

Have you had any surgery? Yes No
Please list: _____

Do you have any allergies? Yes No
Please list: _____

Do you have a history of falling? Yes No

Do you have dizziness or vertigo? Yes No

Do you have balance problems Yes No

Are you taking any **medications**? Yes No
Please list: _____

PAIN:

On a scale of 0 - 10, (0 = no pain and 10 = worst pain you can imagine),
circle the number that best describes the intensity of your pain: **right now**

0 1 2 3 4 5 6 7 8 9 10

at its worst

0 1 2 3 4 5 6 7 8 9 10

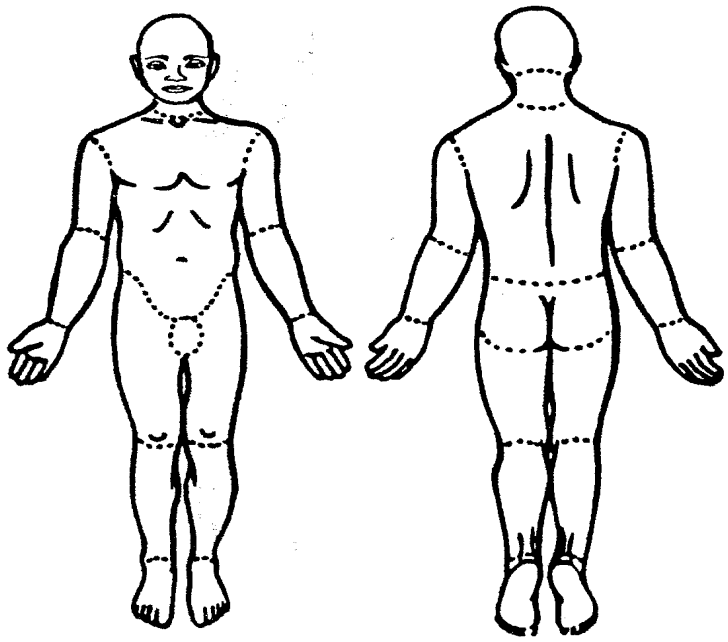
at its least

0 1 2 3 4 5 6 7 8 9 10

Patient Identification

PAIN DRAWING:

Mark the area(s) you are experiencing pain or current symptoms:



Circle the word that best describes your pain:

Aching

Numbness

Pins and Needles

Burning

Stabbing

Dull

Other:_____

Occupation: _____ Currently able to work? Yes No

What activities are limited because of this problem? _____

_____

Your goals: _____

_____

Patient Identification