



North Jersey Professional Rehabilitation, LLC
122 North Church Road, Lower Level
Sparta, NJ 07871

Phone: 973-940-8910 Fax: 973-940-8918

Patient Medical History

Name: _____

Referring Physician: _____

Have you had surgery for this injury? YES / NO Date of injury: _____ Date of surgery: _____
(Circle one)

Are you currently taking any prescription medication or non-prescription medication? YES / NO
(Circle one)

List ALL medications separated by commas: _____

Please select from the list below if you have had an evaluation for this injury by any of the following practitioners.

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> General Physician | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Podiatrist |
| <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Emergency Room Physician | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Other: _____ |

Please select if you have had any of the following special tests – check off all that apply:

- | | |
|----------------------------------|------------------------------------|
| <input type="checkbox"/> X-Ray | <input type="checkbox"/> Bone Scan |
| <input type="checkbox"/> MRI | <input type="checkbox"/> EMG / NVC |
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> Myelogram |

Please select to indicate current or past medical history – check off all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Arthritis/Swollen Joints | <input type="checkbox"/> Gout | Orthopedic Conditions |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Back: Injury/Surgery |
| <input type="checkbox"/> Asthma/Bronchitis/Emphysema | <input type="checkbox"/> Hernia | <input type="checkbox"/> Neck: Injury/Surgery |
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Shoulder: Injury/Surgery |
| <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Elbow/Wrist/Hand: Injury/Surgery |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pins/Metal Implants | <input type="checkbox"/> Knee: Injury/Surgery |
| <input type="checkbox"/> Emotional/Psychological Conditions | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Foot/Ankle: Injury/Surgery |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Pregnant | |
| | <input type="checkbox"/> Stroke/TIA | |
| | <input type="checkbox"/> Thyroid Condition | |