North Jersey Professional Rehabilitation, LLC

Patient Medical History

Name:____

Referring Physician:__________________________________

Diagnosis/Area of Injury:______________________________

Have you had surgery for this Injury? YES / NO Date of Injury:______ Date of Surgery:_______
(Circle One)

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

List Medications______________________________________

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Please circle if have had an evaluation for this injury by any of the following practitioners:

General Physician	Neurologist	Podiatrist
Orthopedist	Physical Therapist	Chiropractor
Emergency Room Physician	Occupational Therapist	Other:__________

Please circle if you have had any of the following special tests :

X-ray	Bone Scan
MRI	EMG /NCV
CT Scan	Myelogram

Please circle to indicate current or past medical history:

Arthritis/Swollen Joints	Gout	Orthopedic Conditions
Anemia	High Blood Pressure	Back Injury/Surgery
Asthma/Bronchitis/Emphysema	Hernia	Neck Injury/Surgery
Coronary Heart Disease	Infectious Disease	Shoulder Injury/ Surgery
Cancer/Chemotherapy/Radiation	Joint Replacement	Elbow/Wrist/Hand Injury/Surgery
Pacemaker/Defibrillator	Pins/Metal Implants	Knee Injury/ Surgery
Diabetes	Osteoporosis	Foot/Ankle/Injury/Surgery
Emotional/Psychological Conditions	Pregnant	
Epilepsy/Seizure	Stroke/TIA	
	Thyroid Condition	