Mountain View REHABILITATION
MEDICAL ASSOCIATES
NONSURGICAL ORTHOPEDICS

Patient History

DATE:_____FULL NAME:_____AGE:_____DOB:_____

DOMINANT HAND: (Circle one) Left / Right WEIGHT:_____HEIGHT:_____

ADDRESS:_____

HOME PHONE:_____CELL PHONE:_____WORK PHONE:_____

If you want to be included in our Patient Portal online please provide your **EMAIL**:_____

PRIMARY INSURANCE:_____SECONDARY NSURANCE:_____

PRIMARY DOCTOR:_____REFERRING DOCTOR:_____

ETHNICITY:_____RACE:_____PREFERRED LAUNGUAGE:_____

CURRENT HISTORY

REASON BEING SEEN:_____

DATE SYMPTOMS STARTED:_____**RELATED TO WORK OR VEHICLE ACCIENT**:_____

DESCRIBE SYMPTOMS:_____

_____

WHAT MAKES SYMPTOMS BETTER:_____

_____

WHAT MAKES SYMPTOMS WORSE:_____

_____

WHAT HAVE YOU TRIED (examples: Physical Therapy, Chiropractor, Injections, Acupuncture)_____

_____

ANY IMAGING OR DIAGNOSITC STUDIES AND WHERE (X-ray, MRI, CT, EMG):_____

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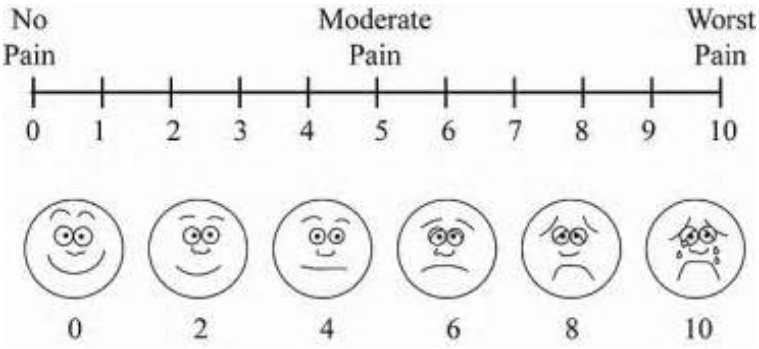
PAIN SCALE within the last week Today (0-10):_____Bad day (0-10):_____Good Day (0-10)_____



Medication & Supplement Name	**Medication & Supplement Dosage**
1)_____	_____
2)_____	_____
3)_____	_____
4)_____	_____
5)_____	_____
6)_____	_____

MEDICATION ALLERGIES (INCLUDE TYPE OF REACTION): _____

_____

PAST MEDICAL HISTORY CIRCLE IF YOU HAVE ANY OF THE CONDITIONS, AND ADD ANY OTHER MEDICAL ISSUES
HEART - BLOOD PRESSURE – CHOLESTEROL – LUNG – ASTHMA – STOMACH – ULCERS – DIABETES – THYROID – ARTHRITIS SEIZURES – HEAD INJURY – INFECTIONS – TUBERCULOSIS – AIDS – OSTEOPOROSIS – GOUT – STROKE – KIDNEY – PROSTATE - NERVE OR MUSCLE DISEASE – DEPRESSION – BIPOLAR – ANXIETY-OTHER:

_____

_____

PAST SURGICAL HISTORY AND DATES: _____

_____

_____

Mountain View Rehabilitation Medical Associates
380 Sierra College Drive, Ste 200 | Grass Valley, CA 95945
Phone: 530.477.0893 | Fax: 530.477.1450

www.mtnviewrehab.com

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FAMILY MEDICAL HISTORY (Briefly list any health problems with blood relatives) _____

IS YOUR FATHER ALIVE: _____ ILLNESSES? _____

IS YOUR MOTHER ALIVE: _____ ILLNESSES? _____

BROTHER/SISTER ILLNESSES: _____

OTHER: _____

SOCAIL HISTORY

(CIRCLE ONE) MARRIED/SINGLE/SIGNIFICANT OTHER/DIVORCED/WIDOW # OF CHILDREN: _____

DO YOU SMOKE? YES____ NO ____ ANY HISTORY OF SMOKING? YES ___ NO ___ YEAR QUIT: _____

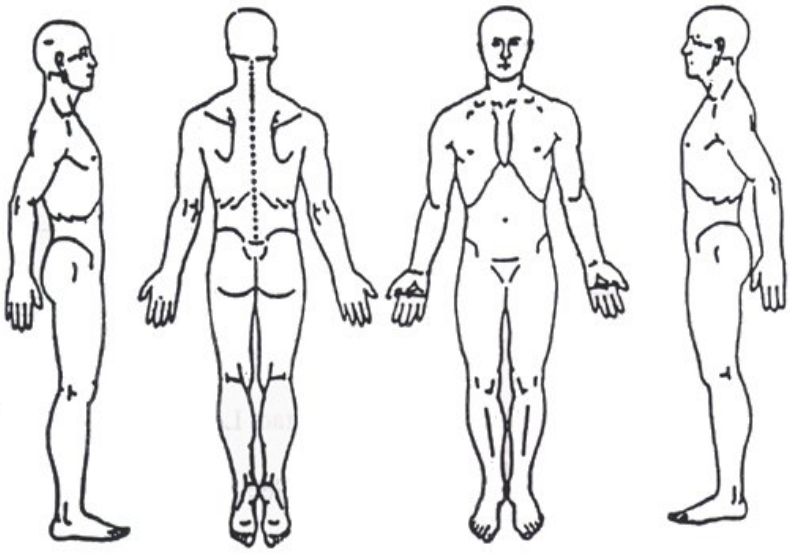
DO YOU USE ALCOHOL? YES___ NO ____ IF YES, HOW OFTEN _____ HOW MANY _____

ANY HISTORY OF ALCOHOL OR DRUG ABUSE? _____

OCCUPATION: _____ DATE LAST WORKED: _____

TO ALL FEMALE PATIENTS*: FOR YOUR SAFETY, PLEASE INFORM THE DOCTOR IF YOU ARE, OR THINK YOU MAY BE, PREGNANT, PRIOR TO ANY TREATMENT INCLUDING X-RAYS AND EXAMINATIONS*

PAIN DIAGRAM - PLEASE MARK THE AREAS ON YOUR BODY WHERE YOU NOW FEEL PAIN USING THESE CODES: ACHE>>>>> NUMBNESS ===== PINS AND NEEDLES 00000 BURNING XXXX STABBING /////



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