GSC THERAPY SERVICES

Patient Information

Name	
DOB	
Height	
Weight	

Current Medical History

Diagnosis	Date of Injury	

Medical Services for this Injury:

	Date		Date		Date
☐	X-Ray	☐	ER Visit	☐	Chiropractor
☐	MRI	☐	CT Scan	☐	Neurologist
☐	PT/OT	☐	Myelogram	☐	Orthopedist
☐	Occupational Med.	☐	EMG/NCV	☐	Podiatrist

Indicate with an 'X' any symptoms you are currently suffering from:

☐	Dizziness/Fainting	☐	Nausea/Vomiting	☐	Numbness/tingling
☐	Difficulty swallowing	☐	Changes in bladder function	☐	Fever/chills/ night sweats
☐	Shortness of Breath	☐	Changes in bowel function	☐	Increased pain at night

Is this a work related accident?	☐	Yes	☐	No
Is this injury related to a motor vehicle accident?	☐	Yes	☐	No
Have you had surgery for this injury?	☐	Yes	☐	No
Have you had physical therapy for this injury?	☐	Yes	☐	No
Are you taking any prescription or non-prescription medications?	☐	Yes	☐	No

Please list:

☐	Muscle Relaxers:	
☐	Pain Medications:	
☐	Anti-Inflammatories:	

Past Medical History

Please mark the appropriate box if you have ever suffered from any of the following health problems:

☐	Allergies	☐	Epilepsy/Seizures	☐	Kidney Problems
☐	Anemia	☐	Fractures	☐	Liver Problems
☐	Currently pregnant?	☐	Frequent Falls	☐	Nervous Disorders
☐	Arthritis/Swollen Joints	☐	Headaches (Severe/Frequent)	☐	Osteoporosis/Osteopenia
☐	Blood Clot/Embolus	☐	Heart Attack or Angina	☐	Pins or Metal Implants
☐	Cancer/Chemotherapy/Radiation	☐	Heart Disease/CHF	☐	Sensivity to Heat/Cold
☐	Circulatory Problems	☐	Heart Surgery	☐	Sleeping Problems/Disorders
☐	Diabetes	☐	Hernia/Appendectomy	☐	Stroke/TIA
☐	Do you have a pacemaker?	☐	High Blood Pressure	☐	Thyroid Problems/Goiter
☐	Do you smoke?	☐	HIV/AIDS/Hepatitis	☐	Tuberculosis
☐	Emphysema	☐	Joint Replacement	☐	Vision or Hearing Problems
				☐	Weight Loss/Energy Loss

Please list any surgeries you have had:

Signature

Patient Signature		Date	
Medical history reviewed and discussed with patient			
Therapist Signature		Date	