Patient Identification Sticker

SHELTERING ARMS – Patient Medical History Summary List

Please describe your current condition: ____
____

Date when current condition began: ____

Please circle ALL of the medical conditions that apply to you:

Arthritis	Fibromyalgia	Metal Implants	Rheumatoid Arthritis
Asthma	Fracture	Neurological Disease	Seizures
Back Problems	Hearing Loss	Numbness / Tingling	Shortness of Breath
Cancer	Heart Disease	Osteoporosis	Stroke / TIA
Chronic Fatigue Syndrome	High Blood Pressure	Pacemaker	Swallowing Problems
Diabetes	Incontinence	Pregnancy	Vertigo
Dizziness	Kidney Disease	Respiratory Disease	Visual Impairments

Other Medical Conditions: ____

Previous Surgeries: ____

Have you had any of the following: X-ray MRI CT Scan Myelogram EMG / NCS Swallow Study
Results: ____

Please list ALL current medications (prescription AND non-prescription): ___________________________
____
____

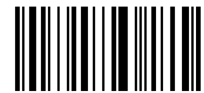
Are you allergic to latex (circle)? NO YES

Medication Allergies (circle)? NONE YES (please list): ________________________________
____

Have you fallen in the past year (12) months?	NO	YES
Do you feel unsteady when walking or standing?	NO	YES
Do you worry about falling?	NO	YES

What are you goals for therapy? ____

please turn over to complete the other side



Are you experience pain right now? NO YES

If YES, please describe your current pain: ____
____

Please rate your pain 0 to 10 (0 = no pain, 10 = extreme pain):	**Now** _____/10 **Worse** ______/10 **Best** ______/10
Shade in the <u>specific</u> area(s) where you are having pain related to your <u>current condition</u>:	Front View R L Back View L R

Patient/Guardian Signature: ________________________ Date: _______________

(For Internal Use Only)

- ☐ Contents of this form have been reviewed and discussed with patient
- ☐ Fall Risk Education Material was provided to patient

Therapist Signature: ______________________________ Date: _______________ Time: _________