Bloomington Rehabilitation ASSOCIATES
1015 South Mercer Avenue, Bloomington, IL 61701
Telephone (309) 662-7500
Fax (309) 662-7333

PATIENT INFORMATION

Patient Name _____ Date _____
Date of Birth _____ Age _____ Sex _____ Marital Status _____ Handedness: R _____ L ____
Height _____ Weight _____ Weight Problems? Yes _____ No _____ How Long? _____
Telephone Numbers: Home ( ) _____ Work ( ) _____
Home Address: _____
City: _____ State _____ ZIP _____
Primary Physician: _____ Referring Physician: _____
Insurance: _____

Reason for Consultation: _____
In your own words, describe your problem/symptom and when and how did it occur:

_____
_____
_____
_____

General Health Review

Medical History: (heart disease, stroke, cancer, arthritis, diabetes, high blood pressure, psychiatric illness, etc)

_____
_____
_____
_____

Surgical History: (unrelated to pain; such as gall bladder surgery, appendectomy, etc.) please indicate date:

_____
_____
_____

Surgical History: (RELATED to pain or current condition such as laminectomy, fusion) please indicate date:

_____
_____
_____
_____

Allergies or Side Effects: (include medications, anesthetics and food allergies as well as a description of your reaction)

_____
_____
_____
_____

Current Medications: (prescription and non-prescription medications, herbal remedies, vitamins, birth control pills if applicable) please indicate dosage and schedules

_____
_____
_____
_____
_____
_____
_____

Do you have any of the following? (Circle all that apply)

Headaches	Stomach Pain	Chest Pain	Vision Problems
Nausea	Shortness of Breath	Hearing Problems	Vomiting
Urinary Problems	Dizziness	Constipation	Rashes
Difficulty Swallowing	Diarrhea	Swollen Joints	
Chronic Fatigue	Others: _____		

Social, Environmental and Functional History

With whom do you live? _____

Type of Home: _____ 1 Story _____ 2 Story _____ Multi-Level

_____ House _____ Apartment _____ Mobile Home

_____ Own _____ Rented _____ # of steps inside/outside

Are there any substance abuse issues in the household? _____

If yes, please explain: _____

Highest Education Level: _____

Are there any recent or ongoing significant emotional stressors? YES _____ NO _____

Are You currently employed? _____

Company/Nature of Job: _____

Duration of Employment: _____

Did your current complaint occur at work? YES _____ NO _____ if YES, When did it occur: _____

Are you still actively working: YES _____ NO _____ if NO, Duration of time off work: _____

Job Satisfaction (present and past) (Scale 1-10) _____

Are you able to walk independently? YES _____ NO _____ If no, please explain _____

_____

Do you use any of the following to walk? Cane _____ Walker _____ Wheelchair _____ None _____

Do You have any difficulties in your self-care activities? YES _____ NO _____

If yes, what particular task (s) _____

LEGAL MATTERS

Is your pain/injury a workman's compensation issue? YES _____ NO _____

Are you presently involved in a lawsuit? YES _____ NO _____ If YES, please explain _____

_____

Are you currently receiving any disability compensation? YES _____ NO _____

Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____