NEURO-REBAB ASSOCIATES
PATIENT HISTORY

Name:	Date:
Referring Physician:	DOB / Age:
Type of Injury / Illness:	Date of Injury / Illness:

Medical History

History of current medical diagnosis:

Have you had any prior head injuries? ___ Yes ___ No If yes, date(s): _____

Were you hospitalized? ___ Yes ___ No ____ ER only If yes, where and dates:_____

Have you had an MRI: ___Yes ___ No If yes, when: _____ CT __Yes __ No If yes, when: _____

What were the findings?

What types of treatment have you had: (medical, therapy, counseling, etc.)

Names of people who have provided treatment:

Describe any relevant prior medical history or medical problems:

Any chronic problems for which you were receiving treatment?

Current Medications / dosage:

Are you having residual problems in any of the following areas: (please explain)

Physical (balance, hearing, dizziness, headache, light/noise sensitivity, sleep, etc):

Social / Emotional (depression, anxiety, isolation, behavioral changes, etc):

Cognitive: (concentration, memory, organization, processing, expressing abstract ideas, reasoning, judgment)

Other:

Do you do anything to compensate for these problems:

Educational and Employment Background : Level of education: _____ Degree:_____ Grade Average:_____

Current Employment: _____ How long? _____

Previous employment:

Describe your job or school demands:

Has your ability to perform your job changed in any way? Yes No If yes, explain:

Personal Information

Currently: Single Married Separated Divorced Widowed Number of children: _____ Ages: _____

Has your ability to perform your duties at home changed? Yes No If yes, explain:

What are your goals and expectations of therapy? What would you like to be able to do that you are not doing now?