Griffin Hospital

Griffin Hospital Rehabilitation Services

350 Seymour Avenue, Derby, CT 06418
Phone (203) 732-7445 Fax (203) 732-7395

PATIENT MEDICAL HISTORY

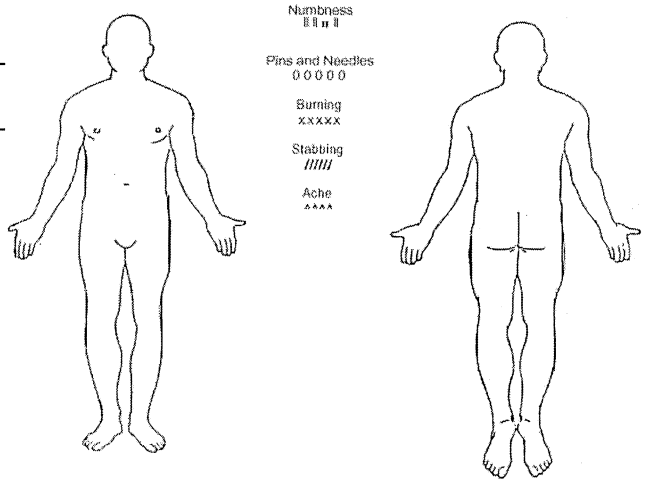
Name: _____ DOB _____ Date: _____

- Are you receiving any home care services such as visiting nurse, home health aide, homemaker, or therapy? Yes No Are you currently participating in Cardiac Rehabilitation? Yes No
- What are your present symptoms and when did they start? _____

  _____
- Do you have pain? Yes No Numbness or tingling? Yes No
- On a scale of 1 – 10, with 10 being excruciating pain, how would you rate your pain?

  1 2 3 4 5 6 7 8 9 10
- How would you describe your pain? ***Sharp Dull Throbbing Burning Aching Constant Intermittent*** (circle all that apply)

Please mark the location of your pain:



- What makes your pain better? _____
- What makes your pain worse? _____
- Height: _____ Weight: _____
- Are you pregnant? Yes No
- Do you have any contagious diseases? Yes No
- Have you fallen? Yes No Date of most recent fall _____
- Past Medical History: _____

  _____
- Past Surgical History: _____

  _____

  Any metal implants? Yes No Location: _____
- Were you injured at work or in a car accident? Yes No
- If "Yes", what type of injury and date of injury? _____

- Do you have any allergies? Yes No If yes, to what? _____
- What medications are you currently taking? _____
  _____
  _____
- Have you had a recent x-ray, CT scan, MRI or other diagnostic test? Yes No
  If yes, what? _____ Was it done at Griffin? Yes No
- Have you received physical therapy in the past calendar year? Yes No
  If yes, for what reason and for how many visits? _____

Patient Specific Functional Scale

- Today, are there any activities that you are unable to do or are having difficulty with because of your _____ problem?

List **up to three (3)** important activities you are having difficulty with and rate EACH on the 0-10 scale.
Zero (0) = unable to perform the activity.
Ten (10) = able to perform the activity at the same level as before the injury or problem.

- **Problem 1.** _____

0	1	2	3	4	5	6	7	8	9	10
Unable to perform										Able to perform activity at same level before injury

- **Problem 2.** _____

0	1	2	3	4	5	6	7	8	9	10
Unable to perform										Able to perform activity at same level before injury

- **Problem 3.** _____

0	1	2	3	4	5	6	7	8	9	10
Unable to perform										Able to perform activity at same level before injury

Score: _____ / _____ = _____
(Total) (# Items) (Average score)

MDC for average score = 2 points MDC for any single item = 3 points

Patient Signature_____ Date _____ Time _____

PATIENT _____ DOB _____