GALLOWAY RIDGE at Farrington

Center for Physical Rehabilitation
50 Craggenmore Close • Pittsboro, NC 27312
Phone: 919•545•2633 Fax: 919•545•2654

Medical History/Subjective

Today's Date: _____

Your Name: _____ **Date of Birth:** _____

Emergency Contact Name _____ **Emergency Contact Phone #:** _____

Physician Name: _____ **Diagnosis:** _____

Medical History

(Please check all that apply; a blank is left for additional medical issues not listed.)

☐ Heart Disease	☐ Diabetes	☐ High Blood Pressure	☐ Pacemaker
☐ Cancer	☐ Tuberculosis	☐ Visually Impaired	☐ Epilepsy
☐ HIV/AIDS	☐ Arthritis	☐ Hearing Impaired	☐ Stroke
☐ Fibromyalgia	☐ Asthma	☐ Scoliosis	☐ Hepatitis
☐ Latex Allergy	☐ Pregnant	☐Other:	

Please list the current medications that you are taking. (*If you have a list, we can make a copy.)*

Describe your pain or condition; when (the approximate date) and how the injury and/or symptoms occurred:

Are you having any level of difficulty performing the following actions? *(Please check all that apply.)*

☐ Speaking Clearly	☐ Sitting	☐ Standing	☐ Walking	☐ Stairs
☐ Lifting	☐ Carrying	☐ Driving a car	☐ Overhead reaching	☐ Eating
☐ Housework	☐ Yard work	☐ Understanding	☐ Remembering things	☐ Drinking liquids
☐ Understanding others		☐ Finding the right words		

Do you have transportation concerns? ☐ Yes ☐ No

Are you the caregiver of children or other family member who has care issues? ☐ Yes ☐ No

To the best of my knowledge and belief the information I have given above is complete and true.

Patient Signature: _____ **Date:** _____