GALLOWAY RIDGE
AT FEARRINGTON

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:** _____