

Welcome to Westlake Rehab and Wellness Center. We are glad you have chosen our facility. Please fill out the following information so we may better serve you.

Name: _____ DOB: _____ SS#: _____ Physician: _____

Address: _____ City: _____ Zip: _____

Home#: _____ Alternate#: _____ E-mail: _____

Emergency contact name: _____ Phone#: _____

Parent/Guardian (if minor):

Name: _____ Relation: _____ Cell#: _____ Work#: _____

Pain and symptoms of current chief complaint (circle all that apply):

Chief Complaint: _____

Dominant Hand: Right Left Was this an injury? Yes No Date of injury: _____

Describe your injury: _____

If non-injury, how long have you had your chief complaint _____

Have you had surgery for this? Yes No

Type/date of surgery? _____

Please rate your pain today: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (emergency room)

Pain at rest Pain with motion Swelling Trouble sleeping due to chief complaint

Numbness/tingling Radiating pain

Describe: _____ Describe: _____

Treatment you have had for current injury (circle all that apply):

Previous surgery Yes No Describe: _____

MRI X-rays Anti-inflammatory meds Splinting/bracing Oral steroids

Muscle relaxers Pain medication Previous therapy Nerve blocks Cortisone injections

Current medications: _____

Do you have any medication or other allergies? _____

Medical history (circle all that apply):

High blood pressure Heart disease Lung disease Hepatitis A B C Tuberculosis

Arthritis Diabetes Cancer HIV Other: _____

Patient Signature: _____ Date: _____