

**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#: \_\_\_\_\_

Describe the main reason for your visit:

\_\_\_\_\_

Date of injury: \_\_\_\_\_ If non-injury, how long have you had chief complaint? \_\_\_\_\_

Is this a workers compensation claim? Y N Is this related to an automobile accident? Y N

Do you exercise? Y N If yes, how often? \_\_\_\_\_ times per week/month

**Past Medical History:**

Have you previously been diagnosed with, treated for or received any of the following?

Yes	No	Heart disease	Yes	No	Artificial joints
Yes	No	High blood pressure	Yes	No	Unexplained weight loss/gain
Yes	No	Asthma/breathing difficulties	Yes	No	Night sweats
Yes	No	Kidney disease	Yes	No	Change in bladder/bowel control
Yes	No	Diabetes	Yes	No	HIV/AIDS
Yes	No	Dizziness/fainting	Yes	No	Hepatitis (type) _____
Yes	No	Stroke	Yes	No	Cancer (type) _____
Yes	No	Seizure/epilepsy	Yes	No	Depression
Yes	No	Rheumatoid arthritis	Yes	No	Anxiety
Yes	No	Osteoporosis/osteopenia	Yes	No	Numbness in legs or arms
Yes	No	Are you pregnant?	Yes	No	Other: _____
Yes	No	Do you smoke?			
Yes	No	Angina/chest pain/heart attack			
Yes	No	Heart rhythm disturbance/irregular heart beat			
Yes	No	Pacemaker/automatic implantable defibrillator			

**Past Medical Treatment**

Please mark all that apply to your current chief complaint.

- |   |  |
|---|--|
| <input type="checkbox"/> Pain medication      | <input type="checkbox"/> Anti-inflammatory medication      |
| <input type="checkbox"/> Muscle relaxers      | <input type="checkbox"/> Oral steroids                     |
| <input type="checkbox"/> X-rays               | <input type="checkbox"/> MRI                               |
| <input type="checkbox"/> CT/myelogram         | <input type="checkbox"/> Rest                              |
| <input type="checkbox"/> Physical therapy     | <input type="checkbox"/> Chiropractic treatment            |
| <input type="checkbox"/> Casting              | <input type="checkbox"/> Bracing/splinting                 |
| <input type="checkbox"/> Cortizone injections | <input type="checkbox"/> Spinal epidural steroid injection |
| <input type="checkbox"/> Surgery              |  |

Please list all surgeries you have had:

Please list all current medications (prescription and over the counter):

Drug or other allergies:

Patient Signature: \_\_\_\_\_