



3377 Compton Road, Suite 140  
Cincinnati, Ohio 45251

(513) 245-0100

**Beyond Limits Rehabilitation – Medical History/Questionnaire**

**Today's Date** \_\_\_\_\_

To be completed by the patient or guardian – Please Print

**Name:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_ **Sex:** \_\_\_\_\_

**Driver's License:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ **Date of next physician's visit:** \_\_\_\_\_

**Chief Complaints: (What problems are you having?)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Date of injury/when pain started?** \_\_\_\_\_ **Date of surgery (if applicable):** \_\_\_\_\_

**Have you had physical therapy of chiropractic treatment this year? Y N** If yes, where: \_\_\_\_\_

**Do you smoke? Y N** If so, how many packs /day? \_\_\_\_\_

**Do you drink alcohol? Y N** How much? \_\_\_\_\_

**Do you regularly exercise? Y N**

**Do you have any drug allergies: Y N** Please specify \_\_\_\_\_

**Please list your current medications: If additional space is needed, please use reverse side of page**

Name of Medication	Dosage	Directions	Date Stopped	Reason/Doctor who prescribed

**Have you ever had the following (circle yes or no, leave blank if uncertain)**

Anemia	Y N	Dizziness or Fainting Spells	Y N	Pacemaker	Y N
Arteriosclerosis	Y N	Epilepsy	Y N	Phlebitis	Y N
Arthritis	Y N	Gastrointestinal problems	Y N	Pneumonia/Respiratory problems	Y N
Asthma/Emphysema	Y N	Heart Disease	Y N	Pregnant currently	Y N
Back/Neck Trouble	Y N	Hernia	Y N	Skin Disease/Rashes	Y N
Bleeding Tendency	Y N	High or Low Blood Pressure	Y N	Stroke	Y N
Blood Clots	Y N	Incontinence	Y N	Thyroid Disease	Y N
Cancer	Y N	Kidney Disease	Y N		
Circulatory Condition	Y N	Metal Implants	Y N		
Depression	Y N	Migraines	Y N		
Diabetes	Y N	Mitral Valve Prolapse	Y N		

**If you answered yes to any of the items above, please briefly explain and give the date. Include pertinent information regarding your past medical history:**

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**Previous Surgeries (Please state year and what illness/surgery you had)**

<u>Date/Year</u>	<u>Illness/Operation</u>	<u>Date/Year</u>	<u>Illness/Operation</u>

\_\_\_\_\_ **I authorize Beyond Limits Rehabilitation to render appropriate evaluation and therapy services in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time in writing. In addition, Beyond Limits Rehabilitation may terminate services by notifying me in writing.**

_____	_____
<b>Patient Name (Please print)</b>	<b>Date</b>
_____	_____
<b>Patient/Guardian Signature</b>	<b>Date</b>