

# ***NORTHEAST REHABILITATION, INC.***

HAND THERAPY, ORTHOPEDIC AND SPORTS PHYSICAL THERAPY

Sudhir V. Tawalare, PT, OCS, CHT. NY License 012255-1, NJ License 40QA00594800

Maria Moldovan, PT NY License 027305

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

To help us better evaluate your condition please complete this form to the best of your knowledge.  
If you have any questions please ask for assistance. Thank you.

## **MEDICAL HISTORY:**

**Please check any condition you have a history of.  
Items not checked are understood to be negative.**

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Bowel or Bladder Problems
<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Asthma	<input type="checkbox"/> Autoimmune disorder
<input type="checkbox"/> Abnormal Heart Rate	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Recent sudden Weigh Loss/Gain
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Chronic Lung Problem	<input type="checkbox"/> Thyroid Problem (Hyper or Hypo)
<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Chronic Heartburn	<input type="checkbox"/> Diabetes (medication dependent? YES/NO)
<input type="checkbox"/> Angina (chest pain)	<input type="checkbox"/> History of Ulcers	<input type="checkbox"/> Cancer/tumors (where? _____)
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Seizures/Epilepsy
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Chronic heartburn/Intestinal upset
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Hearing problems

Other: \_\_\_\_\_  
\_\_\_\_\_

Do you have a history of fractures?	Yes	No	Where? _____
Do you have a history of back/neck pain?	Yes	No	When? _____
Do you have any metal implants?	Yes	No	Where? _____
Do you smoke?	Yes	No	How much per day? _____
Do you exercise regularly?	Yes	No	How Often? _____
Do you have any known allergies?	Yes	No	Please List: _____

Are you allergic to latex?	Yes	No
Are you pregnant or suspect pregnancy?	Yes	No

## **MEDICATIONS:**

**Please check if you are taking any of the following (Please list names of medications)**

<input type="checkbox"/> Blood Pressure Medication	<input type="checkbox"/> Heart Medication	<input type="checkbox"/> Diabetes Medication (i.e. Insulin)
<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Pain Killers	<input type="checkbox"/> Anti-coagulants (blood thinners)
<input type="checkbox"/> Steroids (Cortisone)	<input type="checkbox"/> Anti-inflammatories	<input type="checkbox"/> Other Medications

275 NORTH MIDDLETOWN RD, SUITE 1B. PEARL RIVER. NY 10965

305 ROUTE 17S, SUITE 3-100A PARAMUS, NJ 07652

WWW.NORTHEASTREHABINC.COM

845-623-6566, f 845-623-6556

