West Texas Rehabilitation Center **MEDICAL/SOCIAL HISTORY**	**MRN #**	
Name	**DOB**	**Today's Date**

What is the reason your doctor sent you for treatment and what do you want us to help you be able to do?

How long have you had this problem? *(please give a date or length of time)*

Medical History

***Have you had therapy for this condition in the past or are you having home nursing or home therapy?**

O Yes O No

(Is any healthcare provider coming to your home to check your blood pressure or give you medications?)

***If Yes, who is the home health agency?** _____

Past Hospitalizations/Surgeries:

Please list medications that you are currently taking.

Medication	Prescribing Physician	Phone # of Prescribing Physician

Do you have any known medication allergies? O Yes O No **If Yes, please list**

Please place an "X" in front of all the answers that apply to you.

O Asthma	O Paralysis	O Congestive Heart Failure	O Degenerative Joint Disease
O Emphysema	O Parkinson's	O Stroke	O Carpal Tunnel Syndrome
O Lupus	O Arthritis	O Traumatic Brain Injury	O Chronic Pain
O Diabetes	O Back Injury	O Chronic Bronchitis	O Depression, Anxiety and/or any other mental illness
O Heart Disease	O Vision Problems	O Hearing Problems	
O Cataracts	O Bone Fracture	O High Blood Pressure	O Cancer
O Alzheimer's	O Fibromyalgia	O Multiple Sclerosis	O Tuberculosis
O COPD	O AIDS	O Seizure Disorder	O Hepatitis O Other:
O Incontinence - Bladder		O Incontinence - Bowel	

1. Mobility Assistance
   - O Wheelchair/Power Chair
   - O Cane/Walker
   - O None
2. Weight loss during the last 3 months?
   - O yes, > 6 pounds
   - O yes, 2-6 pounds
   - O no weight loss
   - O unsure
3. Has suffered psychological stress or acute disease in the past 3 months?
   - O Yes
   - O No
4. Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
   - O Yes, severe decline
   - O yes, moderate decline
   - O no change

Has your current illness or injury caused any of the following?

Yes	No		Yes	No	
O	O	Financial Stress	O	O	Sleep Disturbances
O	O	Family Problems	O	O	Irritability
O	O	Anger	O	O	Fear
O	O	Anxiety	O	O	Loss of Appetite
O	O	Sadness	O	O	Frustration
O	O	Depression	O	O	Suicidal Thoughts

Do you smoke? O Yes O No If yes, packs/day: _____		
Do you currently have a **Universal DO NOT RESUSCITATE (DNR) Order?** If yes, please provide a copy.	O Yes	O No
Do you currently have a **Hospital Procedure-Specific DO NOT RESUSCITATE (DNR) Order?**	O Yes	O No
Are you seeing a Social Worker, Counselor, Psychologist, and/or Psychiatrist for your current troubles?	O Yes	O No
Would like to meet about a referral to a Counselor, Neuropsychologist or Social Worker?	O Yes	O No

Printed name of person that completed this form, if not the patient **Relationship to the patient:**

Signature of person that completed this form: **Date:**

Revised 11-6-18