Comprehensive rehab
Dedicated to improving our patients' lives

CLIENT CASE HISTORY

Adults

Client Information

Client's Name____ Today's Date______________________________
Gender M F Physician___________________________ Date of Birth_______________________________
Diagnosis____
Employer/Position____
Do you receive services from any community agencies? _____Yes ______ No
If yes, please list agency, supervisor and phone number. ____

General History

If there was an injury or illness that caused a change in your functioning level, please describe it including date of onset and change in skill level. ____

Have you ever received therapy services in the past? If yes, please describe. __________________________________

Do you currently utilize any adaptive equipment to assist with completion of daily activities? If yes, please describe. ____

Please list any pertinent medical, personal or social information that you feel may contribute to the evaluation or treatment process. ____

Please list any medications you are currently taking and why. ____

Do you have a history of:	Yes	No	Please explain any Yes answers (including dates if pertinent) here
Broken bones/fractures			
Sprains/strains			
Surgeries			
Diabetes			
Liver problems			
Lung problems			
Infectious diseases			
Allergies			
Heart conditions or pacemaker			
High blood pressure			
Cancer			
X-rays, MRI, other tests			
Other			