BARRETT CENTER OUTPATIENT REHABILITATION SERVICES
Medical Case History

Name: _____ Home Phone: _____ Work: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

Please describe your problem over the past 6 months: _____
_____
How has your problem changed over the past 6 months? Is it □ Worse □ Better □ Same
What activities could you do before this problem that you can't do now? _____
_____
What treatment have you had for this problem? _____
_____

Please check if you have any of the following:

NEUROLOGICAL
___Stroke/TIA
___Brain Injury
___Seizures/Epilepsy
___Numbness/Tingling
___Parkinson's
___Dizziness/Vertigo
___Severe Headaches
___Coordination or balance problems
___ Neuropathy

ORTHOPAEDIC
___Fractures
___Dislocations
___Neck Pain/Injury
___Back Pain/Injury
___Arthritis(Osteo/Rheumatoid)
___Osteoporosis
___Joint Replacement
___Recent Falls
Other: _____
_____

CARDIAC/PULMONARY
___High Blood Pressure
___Low Blood Pressure
___Heart Attack
___Chest Pain
___Irregular Heart Beat
___Shortness of Breath
___Asthma
___Pacemaker/Heart Device
Stents
Other:_____

SPEECH AND SWALLOW
___Laryngitis
___Reflux
___Heartburn
___Pneumonia
___Memory Loss
___Hearing Loss
___Speech-Language Problem
Other:_____
_____
_____

ONCOLOGY/METABOLIC
___Cancer
What Kind: _____
___Thyroid Disease
___Diabetes I II
___Blood Clotting Disorder
___Nausea/Vomiting
___Immune Deficiency
___Weight Loss
_____
_____

MISCELLANEOUS
___Vision Loss
___Depression/Anxiety
___Psychiatric Disorder
PROCEDURES
___Upper GI
___Swallow Eval
__Radiation/Chemotherapy
___Videostroboscopy
Other: _____
_____

Current Medications:
□ See attached list
_____
_____
_____
_____
_____
(may use back of form)

Allergies: yes no
List_____
_____
_____
_____
Sulfa Allergy? yes no
Tobacco Use yes no
Alcohol Use yes no

Next doctor appointment
_____
Is this case under litigation?
Yes No

Patient Signature: _____
Date: _____