INTEGRA
Rehabilitation Physicians

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Name				**Today's date**
Address	**City**	**County**	**State**	**ZIP**
Phone (preferred)	(alternate)	**E-mail**		
Age	**Birthdate**	**Emergency contact** (include relationship)	Phone	
Primary care physician	Address	Phone/Fax		
Referring physician	Address	Phone/Fax		
Pharmacy	Address	Phone/Fax		
Occupation	**Highest level of education**			

Marital status (circle) Single Married Divorced Widowed Separated

Race (circle)
American Indian or Alaskan Native Asian Black/African American
Caucasian/White Native Hawaiian or Other Pacific Islander Multiracial
Decline to answer Other:

Are you Hispanic or Latino? (circle) Yes No Decline to answer

Preferred language (circle) English Spanish Decline to answer Other:

Allergies (include reaction):

Current medications	**Dosage**	**Frequency**	**Reason**

Habits (answer if applicable)
Caffeine: ______drinks per day, type:___________
Alcohol: _______drinks per week, type:___________
Tobacco: cigarettes/cigars/chew _______packs per day for the last______ years
If no longer using, how long ago did you quit?
Other past or present drug use (list type and frequency):

Past medical history (Check all that apply)

- ☐ Anemia
- ☐ Amputation
  Site(s)/reason:
- ☐ Arthritis
  Location:
- ☐ Attention deficit disorder
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Back pain
- ☐ Bladder incontinence
- ☐ Bowel incontinence
- ☐ Chemical/drug dependency
- ☐ Clotting disease
- ☐ COPD/Emphysema
- ☐ Cancer
  Type:
- ☐ Coronary artery disease
- ☐ Concussion
  Frequency and dates:
- ☐ Crohns/Ulcerative colitis
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ GERD/Reflux
- ☐ Gout
- ☐ HIV/AIDS
- ☐ Hearing problem
- ☐ Heart attack/heart disease
- ☐ Heart murmur
- ☐ Hepatitis
  Type:
- ☐ Hernia
  Type/location:
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Irritable bowel syndrome
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lyme disease
- ☐ Lymphedema
- ☐ Migraines
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker/AICD
- ☐ Peripheral neuropathy
- ☐ Peripheral vascular disease
- ☐ Pulmonary embolism
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatoid arthritis
- ☐ Seizure disorder/Epilepsy
  Date of last seizure:
- ☐ Skin disease
  Type:
- ☐ Spinal cord injury
  Level/Cause:
- ☐ Stroke
- ☐ Swelling
  Site:
- ☐ Traumatic brain injury
- ☐ Pressure ulcer
  Location:
- ☐ Urinary Tract Infection

Please list any other medical problems, conditions, and/or major hospitalizations not listed above:

Past surgical history: Please list any operations and approximate date

Family history

Relationship	Gender: M or F	Current status: Alive or Dead	Current age or age at death	Any major health problems and cause of death (if applicable)
Mother				
Father				
Sibling				
Sibling				
Sibling				
Child				
Child				
Child				

How did you hear about Integra Rehabilitation Physicians? (circle)
Physician referral   Non-physician healthcare referral   Website/internet search
Friend/family referral   Insurance listing
Social media (facebook, twitter)
Printed Ad   Other: