NEW CLIENT MEDICAL INFORMATION

We are committed to providing our clients with the best care, to do this it is essential that your rehabilitation records are up to date and accurate. Please complete the following:

Client Name: ____ Date: ___________________

Emergency Contact

Name: ____ Phone: _________________

Relationship to client: __________________________________

Health History

Do you have or have had a history of:

- ☐ Arthritis
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Joint replacement
- ☐ Blood clots
- ☐ Lung disorder
- ☐ Pacemaker
- ☐ Cardiac condition
- ☐ Seizures
- ☐ Dizzy spells
- ☐ Diabetes
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Hepatitis A, B, or C

Provide details regarding condition(s) checked____

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Do you have any allergies or are you sensitive to lotions, tapes or latex? ☐ Yes ☐ No

If yes, please specify:____

Do you currently have a DNR (Do Not Resuscitate) order? ☐ Yes ☐ No

____
Client signature or personal representative

____
Relationship to client

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