REHABILITATION SERVICES

Carson Valley Medical Center

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, your therapist will assist you. Thank you!!

Have you EVER been diagnosed as having any of the following conditions?

Cancer	YES	NO
If YES describe what kind:	_____	
Heart problems	YES	NO
High blood pressure	YES	NO
Asthma	YES	NO
Emphysema	YES	NO
Chemical Dependency	YES	NO
Thyroid Problems	YES	NO
Diabetes	YES	NO
Multiple Sclerosis	YES	NO
Rheumatoid arthritis	YES	NO
Other arthritic conditions	YES	NO
Depression	YES	NO
Hepatitis	YES	NO
Tuberculosis	YES	NO
Stroke	YES	NO
Kidney disease	YES	NO
Anemia	YES	NO
Epilepsy	YES	NO
HIV/AIDS	YES	NO
Other	_____	

Please list any surgeries or other conditions for which you have been hospitalized, including approximate date:

DATE	SURGERY/HOSPITALIZATION
_____	_____
_____	_____
_____	_____
_____	_____

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	INJURY
_____	_____
_____	_____
_____	_____
_____	_____

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or skin patches:

_____

_____

_____

_____

Do you smoke?	NO	YES if so how much per day _____
Do you drink alcohol?	NO	YES if so how much per day _____

NAME: _____ AGE: _____