

MEDICAL HISTORY

ARM Assessment-Rehabilitation-Management
3333 S. Pennsylvania Ave., Suite 100
Lansing, MI 48910

Date: _____

Name: _____

Date of injury: _____

How did your injury/problem occur: _____

Present Complaints: _____

List any past related injuries: _____

Describe you general health: Excellent _____ Good _____ Fair _____ Poor _____

Have you had any of the following medical conditions or problems (within the last year)?

Yes No

Dizzy Spells

Shortness of breath

On Exertion

Laying flat

Chest Pain

Sleeping Difficulty

High/Low Blood Pressure

Fainting Spells

Heart Attack

Infections

Cancer

Diabetes

Thyroid Disease

Yes No

Leg Pain

Muscle Weakness

Headaches - Frequent

Arthritis/Rheumatism

Osteoporosis

Numbness/Tingling Sensation

Arms Hand

Legs Feet

Confusion/Seizures

Stroke/Heart Attack

Back Pain - Recurrent

Bone Fracture

Joint Injury

Please list current medications: _____

Are you allergic to bee stings? Yes No

Are you pregnant? Yes No

Do you have a pacemaker? Yes No

Are you currently experiencing any of the following conditions or situations as a result of your injury of physical condition? (Please mark all that apply)

Unable to participate in normal hobbies and/or interests

Loss of job Permanent Temporary

Lack of emotional support and/or conflict with family/friends

Significant stress Home Work Other

Nervousness Forgetfulness

Moodiness - Excessive Depression

Transportation problems (Needing Community Resources)

Grief due to recent death of family member/friend

Difficulty with daily activities Self care Housekeeping duties

Other (Specify) _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

If you are experiencing any of the concerns indicated above and you would like the opportunity for discussion an/or information, our agency provides a medical social worker to assist you. The social worker is a member of our staff, with an office located within this facility. (This service is at no cost to you)

Please mark statement as it applies to you.

- Yes, I would like an opportunity for discussion with the social worker.
- No, I feel I am coping adequately at this time.
- No, I am receiving counseling from another source.

Occupation: _____

Have you had to discontinue working as a result of you injury? Yes No

If yes, are you on worker's compensation? Yes No

If yes, are you presently working with a vocational rehab counselor? Yes No

PATIENT PAIN INDEX

How often does pain occur?

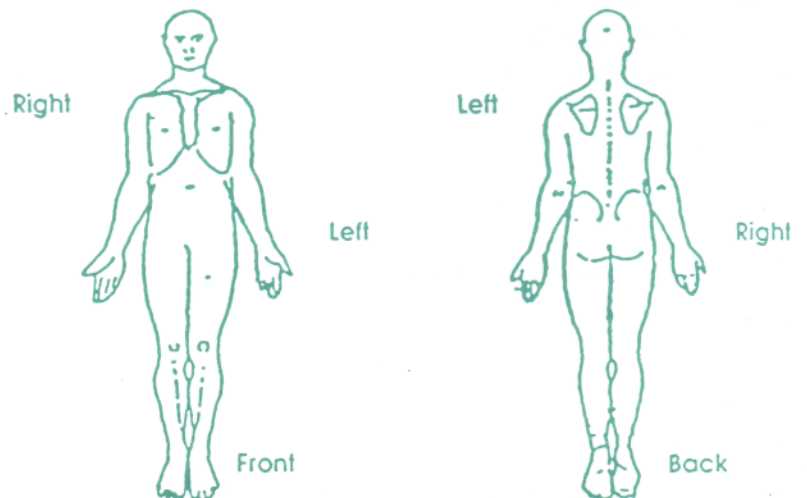
- Constant
- Comes during activity
List activity _____
- Occurs randomly

If you current condition is causing you pain, please put an "X" in the drawing where you feel pain.

If your current condition is causing you pain, please put an "X" in the drawing where you feel pain.

Does pain affect your sleeping?

- Wakes from sleeping
- Prevents from sleeping
- Better after sleeping



In order to get a more accurate idea of your pain; please place an "X" on the scale that best describes the amount of pain you are currently experiencing.

