MAJOR HAÜS
#58 North Montrose Avenue
P.O. Box N-4119
Nassau, Bahamas
Phone: (242) 601-5145

MAJOR CHANGES Rehab Centre
www.majorchangesrehab.com

Email: info@majorchangesrehab.com
Website: www.majorchangesrehab.com
Facebook: www.facebook.com/majorchangesrehab
Instagram: www.instagram.com/majorchanges.rehab

MEDICAL HISTORY FORM - PERSONAL INFORMATION

Patient Information – CHART: ________________

TODAY'S DATE: ____

Referring Physician: ____________________________________

Last Name: ______________ First Name: ______________ MI: ____

Date of Birth: ____________ Age: ___________ Sex (M/F): ______

Marital Status: Single [ ] Married [ ] Divorced [ ] Widowed [ ]

Current Status

Which of the following describes you currently:

[ ] Working; If Yes, then Full Duties [ ] or Limited Duties [ ]

[ ] Not Working as a result of injury or pain

[ ] Not working as a result of other health problem

[ ] Homemaker, Retired or Unemployed

How long have you worked at your current job? ______________

Does your job require lifting, standing, sitting? Yes [ ] No [ ]

Employer at time of injury: ________________________________

YOUR Symptoms

Are your symptoms mostly in your back, neck, hand, legs or elsewhere? ____

How long have you endured these symptoms?

[ ] < 6 Weeks [ ] > 7-12 Weeks [ ] 4 Months or More

Is pain radiating past your knee or elbow? [ ] Yes [ ] No

Does your leg or arm ever go numb? [ ] Yes [ ] No

Have you lost bowel or bladder control? [ ] Yes [ ] No

Your pain is: [ ] Constant [ ] It Comes & Goes

Does pain wake you at night? [ ] Yes [ ] No

What makes the pain better? (Rest, Ice, Heat, Pills) ____________

____

What makes the pain worse? (Sitting, Standing, Lifting) ________

____

Is pain radiating into the arm or leg? [ ] Yes [ ] No

If Yes, describe ____

Lost control over bowel or bladder functions? [ ] Yes [ ] No

If Yes, describe ____

Any weakness or numbness in arms or legs? [ ] Yes [ ] No

If Yes, describe ____

How long can you: Sit ________ Stand _________ Walk ________

Is your pain the result of a: [ ] Fall [ ] Auto Accident [ ] Other

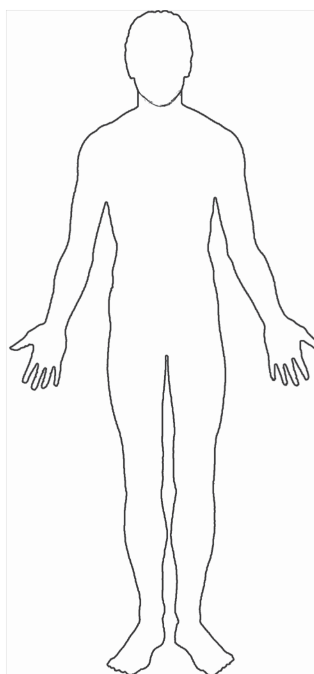
____

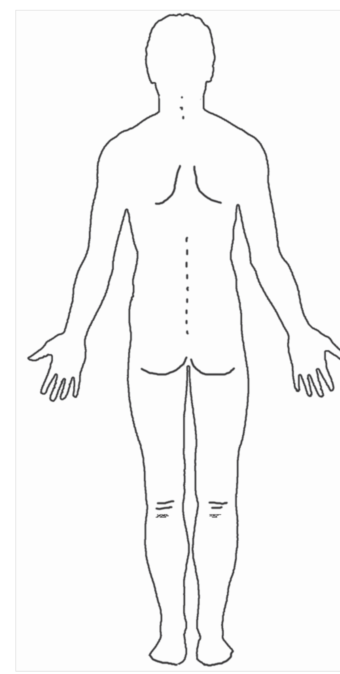
YOUR Pain

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.

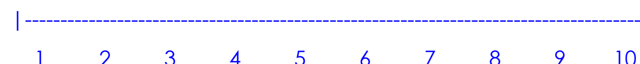
STABBING PAIN ////	BURNING PAIN OOOO
ACHING PAIN XXXX	PINS & NEEDLES VVVV
NUMBNESS ====	

FRONT **BACK**





Circle the pain level on a scale of 1 to 10, 10 being unbearable.



Reviewed By: ____ Date: ____________________