Golden Plains Community Hospital Rehabilitation
Personal Information Form (Please Print)

Patient Name: (Last, First, MI)		
Sex: M or F	Marital Status:	DOB:
Mailing Address:	City, State, Zip	
Social Security Number:	Home Phone:	
Employer:	Cell Phone:	
Employer Address:	Work Phone:	

Referring Doctor: (Name, Location):
Family Doctor: (Name, Location):
Emergency Contact/Relation/Phone:

Primary Health Insurance:
Secondary Health Insurance:

Golden Plains Community Hospital
Rehabilitation Department
100 Medical Drive
Borger, Texas 79007

By signing below, I certify the above information is correct

X____ Date: ______________

GOLDEN PLAINS COMMUNITY HOSPITAL
PATIENT HISTORY

Name ____

Are you a home health patient? ☐ Yes ☐ No

How did you hear about Golden Plains Rehabilitation Center?

Physician Newspaper Previous care here at GPCH

Family/Friends TV/Radio Other

1. **What is your main complaint or problem?**

   Date of onset? ________________ How did it occur? ________________

   ____

   Date of surgery? ________________ Type of surgery? ________________

2. **If you have pain, please circle those words that best describe it.**
   Constant Intermittent Sharp Dull Burning Throbbing Twinge Ache
   Numb Tingle Tight Pulling

3. **Please rate the level of your pain at its best and worst.**

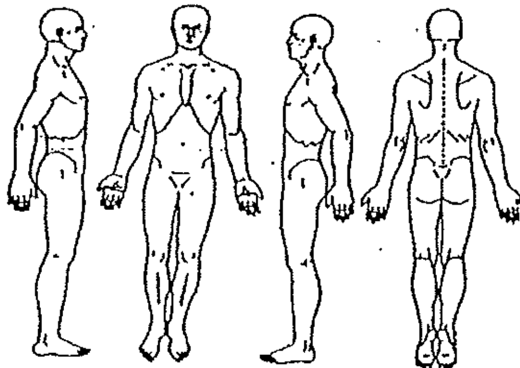
   0 1 2 3 4 5 6 7 8 9 10
   ←No pain--Extreme Agony →

4. **How do you feel in the: Morning?** Better Worse **Afternoon?** Better Worse **Evening?** Better Worse **Night?** Better Worse

5. **What positions o r activities make your pain better?**

6. **What positions or activities make your pain worse?**

7. **Please indicate painful areas by shading models.**



8. **What tests and/or treatments have you had for this problem? What were the findings?**

X-Ray: CT Scan:
EMG: Myelogram:
MRI: Other:

9. **Please list the Medications you currently take & why *OR* attach list**

10. **What is your occupation?** ______________________
    a. **Working:** Full-Time Part -Time Light Duty Not Working
    b. **Physical Work Requirements:** Sedentary Light Moderate Heavy
    c. **Job requires prolonged:** Sitting Standing Bending Walking Lifting Squatting Driving

11. **What functional activities are you currently having problems with?**
    Dress/Bathe Job Duties Housework Cook/Eat Walk Stand Sit Drive Sleep Recreation

12. **Do you have another appointment with your doctor, and if so when?**
    Yes No

13. **What do you hope to accomplish with physical therapy treatment?**

14. **Do you have any medical problems/conditions?**

	YES	NO	Comments/Reactions
Heart Problems			
Blood Pressure			
Diabetes			
Medication Allergies			
Allergies			
Latex Allergy			
Arthritis			
Seizures			
Pregnant			
Osteoporosis			
Cancer			