Walton Rehabilitation Health System
1355 Independence Drive
Augusta, GA 30901
(706) 724-7746

(Addressograph)

1. Age*: _____years old. 2. Please describe the reason for treatment: _____

3. At this present time, would you say your health is: Excellent, Very Good, Good, Fair or Poor.

4. Please place an (X) next to any **problems** you are having **right now**:

___ Coughing spells
___ Fatigue
___ Weight changes
___ Numbness
___ Flu symptoms(past 2 wks)
___ Bowel/Bladder problems
___ Chest Pain/Discomfort
___ Suicidal thoughts
___ Excessive thirst
___ Aching muscles/joints
___ Headaches
___ Shortness of breath (trouble breathing)
___ Trouble with ears/hearing
___ Trouble with eyes/vision
___ Work or family problems
___ Trouble with stomach
___ Trouble sleeping at night
___ Anxiety
___ Depression*
___ Balance Problems*
___ Dizziness*
___ Problems getting up from chair without using arms*

5. Please place an (X) next to any **personal history** you have:

___ Anemia
___ Cancer
___ Heart problems
___ High blood pressure
___ Epilepsy
___ Osteoporosis
___ Asthma
___ Diabetes
___ Hepatitis
___ Multiple Sclerosis*
___ Stroke*
___ Falls in last 6 months*
___ Arthritis
___ Autoimmune Disorder
___ Kidney disease/problems
___ Thyroid problems
___ Chemical dependency (i.e.,alcoholism)
___ Hospitalizations _____

6. Have you had surgery(ies)? Yes ____ No ____Please list_____
7. Do you smoke cigarettes? Yes ____ No ____ packs per day? _____
8. Do you drink Alcohol? Yes ____ No ____ drinks per day? _____ per week _____
9. Do you exercise on a regular basis? Yes ____ No ____ hours per week? _____
10. Do you drink caffeinated beverages? Yes ____ No ____ cups/glasses per day? _____
11. Are you allergic to any medication, foods, or other substances? Yes _____ No _____
    If yes, please list: _____
12. Have you received the flu vaccine during the flu season (October – March)? Yes ____ No ____
13. Have you received the pneumococcus vaccine in the last 5 years? Yes ____ No ____
    If no, information regarding the flu and pneumococcus vaccine will be provided.
14. List all medications you are currently taking and reason for medication: □ None

Medication (prescription and/or over the counter) and Herbs:	**Reason for taking:**

15. Primary Physician _____ Phone _____
    Other Physicians _____ Phone _____

_____ _____
WRH Representative Date Patient Signature Date

* denotes therapist follow-up