Athens Physical Therapy
Athens neuro and Balance Rehabilitation
Physicians Back and Neck Clinic
Better bone clinic
Christopher E. Doerr, D.O., P.C.

NEUROLOGICAL MEDICAL HISTORY

Patient Name____DOB______________

1. Referring Doctor____
2. Describe the problem for which you are seeking therapy____
3. How did the problem start?____
4. When did the problem start____
5. Have you been hospitalized for this and if so, where and when?___________________________________
6. What tests have been done for this problem? (X-ray, MRI etc.)
7. Do you drive? _________ If not, how will you get to therapy?
8. Are you employed? YES / NO Where? _______________________ How many hours per week?________
9. What type of job do you have?____
10. If you are not currently working, do you plan to go back to work?_______________________________
11. What are your hobbies or activities in your spare time?____
12. Do you live alone? YES / NO If not, who lives with you?____
13. Do you live in (circle one): Apartment House Mobile Home
14. How many floors are in your home?____
15. How many steps are there at the entrance to your home?_______________________________________

16. What kind of equipment do you use?

____Wheelchair ____Walker/type______________ _____Cane

____Bedside commode ____Shower/Bath chair _____Hospital Bed

Other:____

17. Please **CIRCLE** activities you are having trouble with:

Bathing	Dressing	Housework
Cooking	Eating & Swallowing	Talking
Understanding what is said to you	Using the phone	Reading
Writing	Memory	Getting out of bed
Getting out of chairs	Getting off toilet	Walking inside the house
Walking outside the house	Balance	Falling to the Ground
Driving	Working (if currently)	Other________________

18. What would you like to work on in therapy?____

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My signature below confirms that the information provided on this document is accurate to the best of my knowledge.

Patient Signature: ____ Date: _______________

Parent/Guardian's Signature: _______________________________________ Date: ______________