

# Neurological Rehabilitation Center LLC

Thank you for carefully  
answering each question!

Patient: Black ink,

Doctor: Red ink

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Work History (Page 1):

Information:

Employer: \_\_\_\_\_ Occupation \_\_\_\_\_

Address: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Start Date: \_\_\_\_\_ Time: \_\_\_\_\_ Last Day Worked: \_\_\_\_\_

Reported to employer? Yes No Name of who you reported it to: \_\_\_\_\_

Reason for termination? \_\_\_\_\_

Work being done at time of Injury? \_\_\_\_\_

In your own words, please describe the accident? \_\_\_\_\_

Returned to work since the accident? No Yes : Light Duty Reg. Duty

Have you been treated/seen by another doctor for this accident? Yes No

Please list names and addresses: \_\_\_\_\_

Describe the type of treatment you received: \_\_\_\_\_

Have you been treated by these doctor/s? \_\_\_\_\_

Better Unchanged Don't Know

Have you had physical therapy? Yes No If yes, How often? \_\_\_\_\_

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**Confidential Patient Information & Agreement (Page 2):** \_\_\_\_\_

Continued.

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After an accident, have you ever had any of the physical complaints similar to what you have now? Yes No  
*Patient: Black ink,*

*Thank you for carefully*

Are these similar complaints the result of a previous accident? Yes No

*Doctor: Red ink*

Please describe the details of the accident.

## Confidential Patient Information & Agreement (Page 3):

Did you have any other serious accidents that required medical attention? Yes No

Please explain: \_\_\_\_\_

Did you have any serious illnesses that required hospitalization? Yes No

Please explain: \_\_\_\_\_

Did you have any surgeries? Yes No If yes, Please describe what and when: \_\_\_\_\_

Did you have any nervous or mental illness? Yes No If yes, Please describe: \_\_\_\_\_

Did you receive any psychiatric care? Yes No

Did you receive a medical discharge from the Armed Forces? Yes No

Where do you have pain in my: Lower Back Mid Back Upper Back

When did it begin: Gradually Suddenly I have pain: All of the time Sometimes

Which leg is it into: Right leg Left leg Both

Where is the tingling and/or numbness in my: Right leg Left leg Both

When does it get worse when I: Cough Sneeze Sit Bend Walk Lift Push Pull

Are your symptoms worse with sexually activity? Yes No

Does it wake you up in the middle of the night? Yes No

Does the weather affect my pain? Yes No

When did it begin: Gradually Suddenly I have pain: All of the time Sometimes

Which arm is it into: Right arm Left arm Both

Where is the tingling and/or numbness in my: Right arm Left arm Both

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*Thank you for carefully  
answering each question!*

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## Confidential Patient Information & Agreement (Page 4):

Thank you for taking the time to fill out this questionnaire. This information is important in the making of an appropriate diagnosis & treatment plan. Please sign below authorizing that the information provided is true, complete & accurate to the best of your understanding. Also, understand that the information provided will be used for use by your doctor at Neurological Rehabilitation Center LLC. Any disclosure is outlined in the privacy policy.

Patient's signature (or guardian's signature) \_\_\_\_\_