2REHAB

Please complete the following to the best of your ability. This needs to be completed by the 3rd Visit. Your therapist will review this with you on your initial evaluation. After you have completed this form, please sign and date it on the bottom of page two (2).

Known Adverse and Allergic Reaction/Known Allergies

☐ **None on Initial Review**

Date	Allergy/Reaction	Date	Allergy/Reaction

Known Significant Medical Conditions Not Noted on Background Information Form

☐ **None on Initial Review**

Known Surgical and Invasive Procedures

☐ **None on Initial Review**

Date	Procedure

Known Current Medications: Prescription/Over the Counter/Herbals/Vitamins/Supplements

List routine medications, nutritionals, herbal supplements, patches, inhalers, ointments used.
If you have a list of medications on another document that we can attach, please **CHECK HERE** ☐
(see attached document with complete list of meds)

☐ **None on Initial Review**

MEDICATION (Include strength if known)	DIRECTIONS (if known)			Discontinued/Added (date and initial)
	DOSE	ROUTE	FREQUENCY	
Example: Aspirin 81 mg	*1 tab*	*by mouth*	*daily*	
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
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				☐ Discontinued ☐ Added

Patient Label

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If you have a list of medications on another document that we can attach, please **CHECK HERE** ☐

(see attached document with complete list of meds)

☐ **None on Initial Review**

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Patient Signature	Date	Time
Intake Therapist Signature	Date	Time
FOR CHANGES		
Therapist Signature	Date	Time
Therapist Signature	Date	Time
Therapist Signature	Date	Time
Therapist Signature	Date	Time

Patient Label