

MEDICAL HISTORY

NAME: _____ Date of birth: _____

Primary Language: _____ Date of most Recent Brain Injury: _____

What times in your life did you suspect to have a brain injury? _____

Description of Brain Injury: _____

In the space provided, write your primary care provider's name and contact information.
If you get a new provider, write the current information in the next available space.

PRIMARY CARE PROVIDER/ CLINIC	Phone Number	Date you began seeing provider.

IMMUNIZATIONS—Attach a copy of your immunization record to this packet.

MENTAL HEALTH—Is there a diagnosis? **YES** _____ **NO** (circle)

If **yes**, in the space provided, write your mental health care provider's name and contact information. If you get a new provider, write the current information in the next available space.

MENTAL/ Behavioral HEALTH CARE PROVIDER	Phone Number	Date you began seeing provider.

HOSPITALIZATIONS/PROCEDURES

In the space provided, please list any hospitalizations or medical procedures (such as surgeries) you have experienced. State where or from whom these occurred; include provider contact information; and indicate whether the hospitalization, surgery or procedure occurred before or after your brain injury.

HOSPITAL/PROVIDER	Reason for Procedure or Hospitalization	Date/s of Procedure or Hospitalization	Circle if this occurred before or after BI.	Phone Number
			Before After	
			Before After	
			Before After	
			Before After	
			Before After	
			Before After	
			Before After	
			Before After	
			Before After	

HOME HEALTH CARE

In the space provided, please list any home health care services you currently receive or received in the past, include dates you received services, contact information, and whether you received services before or after your brain injury.

HOME HEALTH CARE PROVIDER	Reason for Services	Date/s of Receiving Services	Circle if this occurred before or after brain injury	Phone Number
			Before After	
			Before After	
			Before After	
			Before After	
			Before After	

FAMILY HISTORY

In the space provided, please indicate your family’s history for diseases and type of therapy

Diagnosis	Relationship to You	Age started	Therapy
	Maternal or Paternal		
	Maternal or Paternal		
	Maternal or Paternal		
	Maternal or Paternal		
	Maternal or Paternal		
	Maternal or Paternal		
	Maternal or Paternal		

THERAPIES / REHABILITATION

In the space provided, please indicate any therapies/rehabilitation you have received or currently receive. List the type of therapy or rehabilitation (such as OT, PT, or speech), dates you received therapy or rehabilitation, contact information, and if you received this treatment before or after your brain injury.

PROVIDER / CLINIC	Type of Therapy/Rehab.	Date/s of Therapy	Circle if this occurred before or after BI.	Phone Number
			Before After	
			Before After	
			Before After	
			Before After	
			Before After	
			Before After	
			Before After	
			Before After	
			Before After	

In the space provided, please list any other experiences or conditions that would be pertinent to your medical history.

Medication Log

Medication Name	Prescriber	Reason	Date Began	Dosage	Time
					<input type="checkbox"/> AM
					<input type="checkbox"/> PM
					<input type="checkbox"/> AM
					<input type="checkbox"/> PM
					<input type="checkbox"/> AM
					<input type="checkbox"/> PM
					<input type="checkbox"/> AM
					<input type="checkbox"/> PM
					<input type="checkbox"/> AM
					<input type="checkbox"/> PM
					<input type="checkbox"/> AM
					<input type="checkbox"/> PM
					<input type="checkbox"/> AM
					<input type="checkbox"/> PM
					<input type="checkbox"/> AM
					<input type="checkbox"/> PM
					<input type="checkbox"/> AM
					<input type="checkbox"/> PM
					<input type="checkbox"/> AM
					<input type="checkbox"/> PM

