

Medical & Sports Rehabilitation Center Inc

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Functional Performance Assessment Information Page

Patient Name: _____
(Last) (First) (Middle Initial)

Patient Address: _____
(Street) (Apt/Suite)

Patient SSN: _____ Patient Date of Birth: _____

Home Phone: _____ Work Phone: _____

Employer: _____

Contact Name: _____ Contact Phone: _____

Date of Injury: _____ Physician: _____

Diagnosis: _____ Follow Up w/MD: _____

Adjustor/Case Manager: _____

Phone: _____ Fax: _____

(For Office Use Only)

_____ Received MD notes _____ Received Job Description

(For Evaluation Use Only)

Have you ever had a heart attack? YES NO

Have you ever had a stroke? YES NO

Have you ever had heart surgery? YES NO

Have you ever had an abnormal EKG? YES NO

Have you ever been diagnosis with angina, irregular HB, or
Palpitations? YES NO

Do you have high blood pressure? YES NO

*Date last checked: _____

Are you pregnant? YES NO

Are you currently being treated for any other medical problems relevant to your performance of your
work activities? YES NO

If YES, describe: _____

Physician: _____ Phone: _____

Completed By: _____ Date: _____