Rehabilitation Services

Patient History Questionnaire

Patient: _____

MR# _____

Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information.

PERSONAL INFORMATION

I am currently: ☐ Employed ☐ Employed with restrictions ☐ On medical leave ☐ Not employed

Employer: _____ Occupation: _____

Interests/hobbies/exercise: _____

Is there anyone who can assist you with doing home exercises or activities if needed? ☐ Yes ☐ No

Will you have any problems attending therapy sessions? ☐ No ☐ Yes If yes, please describe:

_____

Next scheduled Dr appointment(s): Date_____ Physician_____

Date_____ Physician_____

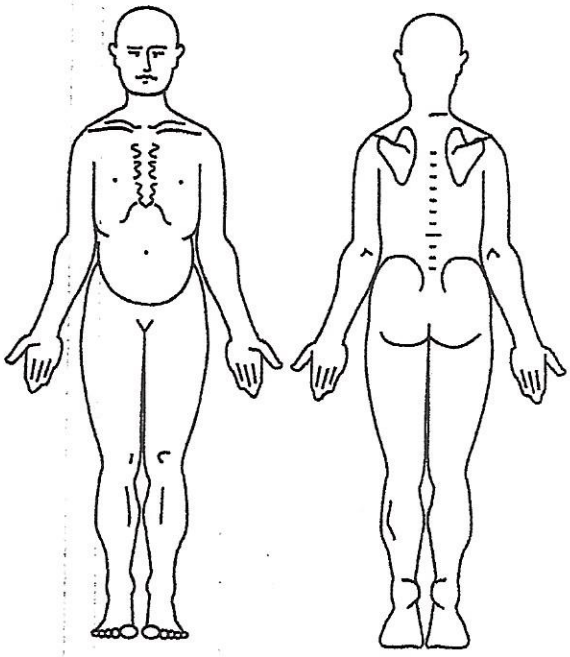
KEY QUESTIONS ABOUT YOUR CONDITION

1. What is your **MAIN** complaint? _____

_____

_____

2. Darken the areas on the body where you are having problems.



3. *Please mark your level of pain with an X along the following lines:*

What is your pain at rest?

No Pain ——————————— *Worst Pain Imaginable*

What is your pain with activity?

No Pain ——————————— *Worst Pain Imaginable*

GENERAL HEALTH

4. At the present time, would you say that your health is: ☐ excellent ☐ very good ☐ fair ☐ poor
5. What is your: Height _____ Weight _____ ?
6. Are you having trouble sleeping? ☐ Yes ☐ No Normal hours of sleep _____hours
   Current hours of sleep _____hours
7. Are you experiencing or have any of the following:

☐ Apprehension
☐ Crying episodes
☐ Low energy or frequent fatigue
☐ Flushing
☐ Increased perspiration
☐ Avoiding or uncomfortable with people
☐ Less talkative than usual
☐ Increased negative feelings about injury or future
☐ Weight loss (10 lbs or more)
☐ Decreased sexual interest

GENERAL HEALTH *(cont)*

8. Medical conditions you have or have had. (check all that apply)

☐ Arthritis
☐ Cancer: ☐ In remission
☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure
☐ Lung Disease
☐ Stroke
☐ Stomach Disorders *(ulcers, etc.)*
☐ Anxiety
☐ Depression
☐ Panic Attacks
☐ Gland Problems *(thyroid)*
☐ Pacemaker
☐ Visual problems
☐ Hearing problems
☐ Seizures/Epilepsy
☐ Other _____
☐ Osteoporosis
☐ Parkinson's disease
☐ Fibromyalgia
☐ HIV + ☐ AIDS

9. Have you had any surgical or invasive procedures? ☐ Yes ☐ No If yes, please list:

_____ _____
_____ _____

10. Uncontrolled leakage of urine? ☐ Yes ☐ No
11. Loss of bowel control? ☐ Yes ☐ No
12. Do you smoke? ☐ Yes ☐ No Packs per day_____
13. Do you drink alcohol? ☐ Yes ☐ No Drinks per week_____
14. Is there any chance you might be pregnant? ☐ Yes ☐ No
15. Are you on a special diet? ☐ Yes ☐ No Specify _____
16. Are you taking any medications (prescription, over the counter, herbal preparations)? ☐ Yes ☐ No If yes, please list or ☐ see attached

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

17. Do you have any allergies (eg. adhesives, latex, cortizone)? ☐ Yes ☐ No If yes, please list with any reactions/treatments:

_____ *Reaction/Treatment:* _____
_____ *Reaction/Treatment:* _____
_____ *Reaction/Treatment:* _____

18. For patients **12 years and younger**, is immunization/vaccination status current? ☐ Yes ☐ No

PERSONAL GOALS FOR THERAPY

19. What do you **WANT TO** achieve from having therapy? Check all that apply:

☐ Improve home activities
☐ Improve leisure/sports activities
☐ Improve self care activities
☐ Improve mobility/walking activities
☐ Improve ability to communicate
☐ Improve swallowing
☐ Decrease or eliminate pain/discomfort
☐ Return to work: ☐ Current job ☐ Other job
☐ Other_____

_____

20. Please include any additional information you feel would help us provide your care (ie. what you think would help, any apprehensions about treatment, special communication, language, spiritual or cultural needs).

_____
_____
_____

To the best of my knowledge, the above information is complete and factual.

_____ _____
Patient Signature ***Date***