

Print Name:	
Date of Birth:	Today's Date:

Rehabilitation Medical History Questionnaire

PLEASE CHECK YES or NO IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Heart Attack / heart disease			Respiratory problems		
Chest pains			Nervous / emotional conditions		
Diabetes			Hernia		
Insulin			Asthma / Pneumonia / Tuberculosis		
Shortness of breath			Jaundice		
Varicose veins / artery disease			Hepatitis		
Heart murmur / abnormal heart beat			Gall bladder problems		
High / Low blood pressure			Injuries to back, legs, arms & joints		
Thyroid problems			A.I.D.S.		
Anemia			Alcohol Abuse		
Osteoarthritis			Cancer - Location _____		
Rheumatoid arthritis			Chemical Dependency		
Osteoporosis			*Head Injury		
Bowel / bladder problems			*Fainting spells		
Abnormal chest x-ray			*Stroke / T IA		
Pregnancy			*Fractures		
Kidney disease			*Epilepsy / Seizures		
Allergies ___ Yes ___ No If yes, please list:					

DO YOU NEED ASSISTANCE WITH ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Bathing			Eating		
Dressing			Swallowing		
Toileting			*Mobility / gait		
Communication of Needs			*Balance		

WITHIN THE LAST THREE MONTHS – HAVE YOU NOTICED ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Choking with meals			Inability to follow directions		
Nausea, vomiting, diarrhea			Nutritional support at home		
Eating less than 50% normal			Activities of daily living problems		
Weight loss > 10 lbs in 1 month			Interference with oral intake		
Chewing / swallowing problems			*Decline in walking		
Food allergies / restrictions			*Balance problems		
Vision problems related to stroke			*Dizziness episodes		

OTHER MEDICAL CONDITIONS: _____

LIST ALL SURGERIES OR INVASIVE PROCEDURES: _____

Print Name: _____ Date of Birth: _____

MEDICATIONS CURRENTLY USED: (you may provide a list)

1.	3.	5.
2.	4.	(Please list separately if more)

LIFESTYLE: Active / Sedentary (circle one)

CHOLESTEROL: Normal / High (circle one)

SMOKE TOBACCO: Yes / No (circle one) **PACKS PER DAY:** _____

DO YOU FEEL SAFE AT HOME? Yes / No (circle one)

ARE YOU IN A RELATIONSHIP IN WHICH YOU ARE BEING HIT, KICKED, SLAPPED OR OTHERWISE HURT? Yes / No (circle one)

WHAT IS YOUR OCCUPATION? _____

ARE YOU CURRENTLY OUT OF WORK BECAUSE OF THIS PROBLEM? Yes / No (circle one)

HAND DOMINANCE? RIGHT-HANDED LEFT-HANDED (circle one)

***HAVE YOU HAD ANY RECENT FALLS?** Yes / No (circle one)

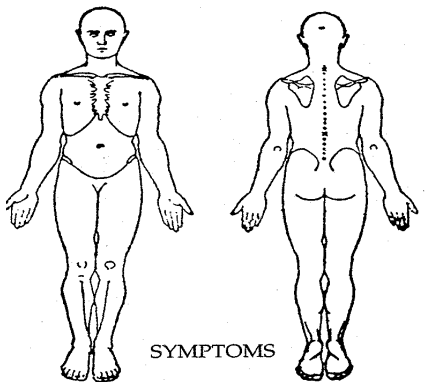
PLEASE RATE YOUR PAIN / SYMPTOMS: 0 = No Pain 10 = Worst pain possible

0-1-2-3-4-5-6-7-8-9-10

IF YOU HAVE PAIN, PLEASE CIRCLE THE WORD(S) BELOW THAT BEST DESCRIBE YOUR PAIN:

Pulsing	Tingling	Aching	Intense
Throbbing	Shooting	Dull	Exhausting
Pounding	Sharp	Sore	Miserable
Quivering	Burning	Tender	Nauseating

MARK THE LOCATION(S) OF YOUR SYMPTOMS ON THE BODY PICTURES TO THE RIGHT



SYMPTOMS

PLEASE LIST 3 PERSONAL GOALS YOU WISH TO ACHIEVE WITH THIS THERAPY PROGRAM:

(For example: decrease pain, return to work, return to sports, recreation, work about the house, etc.)

1.	
2.	
3.	

WHAT MAKES YOUR PAIN BETTER? _____

WHAT MAKES YOUR PAIN WORSE? _____

I certify that I have reviewed the preceding health information with the patient:

Therapist's Signature: _____

***Fall Risk?** Yes ___ No ___