MEDICAL HISTORY

Patient Name:
Date of Birth:
Referring Physician:
Primary Insurance:

To ensure you receive a complete and thorough evaluation, please provide us with the important background information. If you do not understand a question, leave it blank and your therapist will assist you. Thank you.

Allergies: List any medication you are allergic to : _____

Are you latex sensitive? ☐ Yes ☐ No *List any other allergies we should know about:* _____

In your own words, tell us WHY you are here for therapy:

_____

_____

At the present time, would you say that your health is?
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

What is your height? ____ ft ____ in? What is your weight? _____ lbs

Are you under the care of or receiving any of the following? (Please check all that apply)

☐ Chemotherapy	☐ Occupational Therapist	☐ Radiation Therapy	☐ Social Services	☐ Other: _____
☐ Chiropractor	☐ Physical Therapist	☐ Respiratory Therapy	☐ Acupuncture	
☐ Dietician	☐ Psychiatrist/Psychologist	☐ Speech Therapist	☐ Massage Therapist	

Please List All of the Physicians you are currently seeing. Include Name and Phone number.

Provider's Name	***Provider's Phone Number***

Date of last physical exam: _____
[If applicable: Pelvic Exam: _____ ***Urinalysis:*** _____ ***Prostate Exam:*** _____ ***]***
If you have seen any of the above in this calendar year, please describe the reason **(illness, medical condition, etc):**
_____
_____
_____

CO-MORBIDITIES

Have you ever been diagnosed with any of the following conditions? (Please check all that apply)

- ☐ Abdominal Pain
- ☐ Anemia
- ☐ Ankylosing Spondylosis
- ☐ Baclofen Pump
- ☐ Bladder infection
- ☐ Bone/Joint problems
- ☐ Blood Clots
- ☐ Cancer. What kind?_____
- ☐ Chemical Dependency (Alcoholism, etc.)
- ☐ Circulation Problems
- ☐ COPD: Asthma/Chronic Bronchitis/Emphysema
- ☐ Chronic Fatigue Syndrome
- ☐ Chronic Traumatic Encephalopathy (CTE)
- ☐ Congenital Abnormalities
- ☐ Congestive Heart Failure
- ☐ Concussion
- ☐ Constipation
- ☐ CURRENTLY PREGNANT
- ☐ Defibrillator
- ☐ Depression
- ☐ Diabetes
- ☐ DISH (Diffuse Idiopathic Skeletal Hyperostosis)
- ☐ Endometriosis
- ☐ Shunt
- ☐ Fibromyalgia
- ☐ Fibroids/Cysts
- ☐ Guillian-Barre/CIDP
- ☐ Glaucoma
- ☐ Heart Disease/CAD
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Kidney Disease. What kind? _____
- ☐ Kidney Stones
- ☐ Low Back Pain (LBP)
- ☐ Lyme's Disease
- ☐ Marphan Syndrome
- ☐ Menopause (peri or post)
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Osteo-Arthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Painful Intercourse
- ☐ Pelvic Inflammatory Disease
- ☐ Pelvic Pain
- ☐ Prolapse (Bladder, Uterus, etc.)
- ☐Prostatitis
- ☐ Psychological Disorders
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Reiter's Syndrome
- ☐ Seizures
- ☐ Sexually Transmitted Dis. (STD)
- ☐ Sleep Apnea
- ☐ Spinal Stenosis
- ☐ Stent(s): Heart __ Leg __ Other: ___
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Traumatic/Frequent Falls
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ Urinary Tract Infection (UTI)
- ☐ Pain Pump
- ☐ Other: _____

Have you ever had any of the following Surgeries? (Please check all that apply)

☐ Appendix Removed	☐ Rotator Cuff surgery	☐ Total Hip Replacement
☐ C-Section	☐ Total Shoulder Replacement	☐ Total Knee Replacement
☐ CABG (Coronary Artery Bypass Graft)	☐ Hysterectomy	☐ Hernia Repair: ☐ Hiatal ☐ Umbilical ☐ Inguinal
☐ Gall Bladder Removed		

Please list any OTHER significant surgeries or conditions for which you have been <u>treated</u> or hospitalized.

Other Surgeries:

Recent Hospitalizations:

RECENT HEALTH CHANGES

Please check any of the following that are <u>NEW, UNUSUAL, or ATYPICAL</u> of you.

- ☐ Weight loss or gain (circle one)
- ☐ Easy bruising
- ☐ Fatigue
- ☐ Regular cough
- ☐ Arm/ leg swelling
- ☐ Seizures
- ☐ Double Vision
- ☐ Loss of vision
- ☐ Post menopause
- ☐ Urinary incontinence
- ☐ Pregnant or think you may be pregnant
- ☐ Pain that wakes you at night
- ☐ Joint/ muscle swelling
- ☐ Dizziness/ lightheadedness
- ☐ Weakness
- ☐ Fever/ chills/ sweats
- ☐ Tremors
- ☐ Heart racing in your chest
- ☐ Blood in stools
- ☐ Eye redness
- ☐ Problem sleeping
- ☐ Sexual difficulties
- ☐ Hearing problems
- ☐ Problems urinating
- ☐ Nausea/ Vomiting
- ☐ Excessive bleeding
- ☐ Difficulty breathing
- ☐ Numbness or tingling
- ☐ Difficulty swallowing
- ☐ Heartburn/ indigestion
- ☐ Constipation/ diarrhea
- ☐ Skin rash
- ☐ Blood in urine
- ☐ Night sweats
- ☐ Stress at home
- ☐ Pregnant (Either confirmed or possible?)

PERSONAL FACTORS

Where do you live (or intend to live) at the conclusion of this outpatient therapy episode?

☐ Residential Home ☐ Apartment ☐ Assisted Living ☐ Group Home ☐ Other _____

Number of steps to enter home: _____ *Number of steps inside home:* _____

Handrails ☐ Yes ☐ No. If yes, Handrail on ☐Right ☐ Left going up

Laundry on: ☐ 1st floor ☐ 2nd floor ☐ Basement ☐ Other: _____

Master Bedroom on: ☐ 1st floor ☐ 2nd floor

Who do you live with (or intend to live with) at the conclusion of this outpatient therapy episode?

☐ Alone ☐ Spouse/significant other ☐ Child(ren) ☐ Other Relative ☐ Unrelated person(s)

Is this the same living environment as you resided prior to the current illness/injury? ☐Yes ☐ No

What medical equipment do you have? Check all that apply:

☐ Rolling Walker with two wheels ☐ Rolling Walker with four wheels and seat ☐ Straight Cane ☐ Quad Cane
☐ Power Wheelchair ☐ Manual Wheelchair ☐ Bedside commode (3-N-1) ☐ Shower Chair ☐ Shower Bench
☐ Reacher ☐ Sock aid ☐ Hip Kit ☐ Other: _____

During the past month, have you been feeling down, depressed or hopeless? ☐ Yes ☐ No
During the past month, have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐ Yes ☐ No

How much caffeinated coffee or other caffeinated beverages do you usually drink per day? _____
How many glasses of fluid do you consume per day? _____
Do you have a special diet? ☐ Yes ☐ No If yes, specify type (gluten free/dairy free/Lactose free/vegan, etc.):
_____
Do you smoke? ☐ Yes ☐ No How many packs per day? _____ For how many years? _____ If you quit, when? _____
How many days a week do you drink alcohol? _____
If 1 drink equals 1 beer or glass of wine, how much do you usually drink at a time? _____
Are you using, or have you ever used illegal drugs? ☐ Yes ☐ No _____

OCCUPATIONAL PROFILE/FUNCTIONAL PERFORMANCE

Prior to your current course of therapy, were you able to:

Successfully complete basic self-care skills? ☐ Yes ☐ No
Successfully complete cooking, cleaning and other homemaking tasks? ☐ Yes ☐ No
Engage in activities outside the house? ☐ Yes ☐ No If yes, check all that apply:
☐ Work: Occupation: _____ ☐ Volunteer work ☐ Shopping ☐ Church ☐ Recreational sports
☐ Gardening ☐ Yard work ☐ Other: _____

***Please list leisure activities, including exercise routines*:**

_____
_____
_____

***Please list 3 activities that you are unable to do or having difficulty with as a result of your problem*.**

1. _____
2. _____
3. _____

MEDICATIONS

Non-Prescription Medications

Have you taken any of the following in the past week? (Please check all that apply)	
Aspirin	Yes / No
Ibuprofen	Yes / No
Naproxen	Yes / No
Other Anti-Inflammatory Agents	Yes / No
Tylenol/Acetaminophen	Yes / No
Herbal Remedies	Yes / No
Heartburn/Ulcer	Yes / No
Vitamin/Mineral Supplements	Yes / No

Prescription Medications

Patient name: *Date of birth:*

☐ *See Attached List*

Do not use this form if you have a written current medication list. Please give your list to the Intake Specialist who is helping you. A copy of the list will be made and the original will be returned to you.

If you do not have a written list, please use this form and list any prescribed medications including pills, injections, patches as well as any over the counter medications and herbal remedies that you are taking.

Medication	*How often taken?*

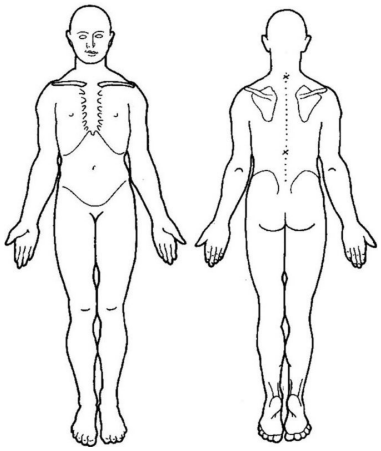
Changes in Medications

Date	*Medication*	*Change*

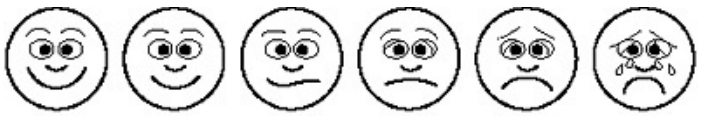
Updated:	*Updated:*	*Updated:*	*Updated:*	*Updated:*	*Updated:*	*Updated:*	*Updated:*

PAIN

Please mark an "X" on the location of your pain ☐*N/A*



Using the scale below, rate your pain on a 0-10 scale; 0 being none and 10 being worst



0 1 2 3 4 5 6 7 8 9 10

Best ____/ 10
Worst ____/ 10
Average ____/ 10
Current ____/ 10

Description of pain: (Circle all that apply OR describe in your own words)
Sharp/Dull/Aching/Burning/Shooting/Catching/Clicking/Diffuse/
Stabbing/Throbbing/Radiating

_____

_____

What makes your pain worse?
What makes your pain better?
Please check one:

- ☐ My pain is always there (continuous)
- ☐ My pain comes and goes (intermittent)

Have you traveled outside of the United States within the last 21 days? Circle one: Yes/No
If yes, please list the country: _____

Name of person that completed this form: _____Relationship to patient:_____
Date: _____