Name:

Rehabilitation Today-Patient Health Questionnaire

Please inform us and list; the name, phone/fax, and/or address of any additional physicians that you wish to be furnished with a copy of your evaluation (Referrin physician will routinely be furnished with a copy).

Do you have a DNR (Do not Resuscitate order)? ☐ Yes ☐ No

Do you have a Health Care Proxy? ☐ Yes ☐ No If yes, who?

What is the date of onset for this injury/illness? ___/___/_____

What is the reason for seeking therapy:

Has this injury/illness occurred in the past? ☐ Yes ☐ No

Are you currently being treated by another healthcare provider for this injury/illness?

Have you had any Physical Therapy in the past 60 days? ☐ Yes ☐ No

If Yes, where did you receive therapy? Date: ___/___/_____

Do you require the use of an assistive device? (example: walker, wheelchair, orthotics, braces, crutches, cane, etc.)

Please specify: ☐Before injury/illness: ☐After injury/illness:

What was your functional status (ability to perform everyday activities) before this injury/illness? Please rate below:

☐ No difficulty ☐ Mild difficulty ☐ Moderate difficulty ☐ Severe difficulty

Do you have any weight bearing restrictions? ☐ Yes ☐ No Please specify:

Have you had a recent cortisone injection? ☐ Yes ☐ No If yes, when? ___/___/_____

Have you had any recent diagnostic testing (MRI, X-rays, CT scans)? ☐ Yes ☐ No If yes, when? ___/___/_____ Where?

Please list all surgeries you have had(include date):

Please list any other significant past medical history:

Are you pregnant? ☐ Yes ☐ No

Past Medical History

Please check if you, or anyone in your family, have ever had any of the following:

➢ Allergies	☐ Self	☐ Family
➢ Arthritis	☐ Self	☐ Family
➢ Broken bones/fractures	☐ Self	☐ Family
➢ Osteoporosis	☐ Self	☐ Family
➢ Blood Disorders	☐ Self	☐ Family
➢ Blood Clot	☐ Self	☐ Family
➢ Circulation/Vasc. problems	☐ Self	☐ Family
➢ Heart Problems	☐ Self	☐ Family
➢ Heart disease	☐ Self	☐ Family
➢ Angina	☐ Self	☐ Family
➢ Heart Attack	☐ Self	☐ Family
➢ High Blood Pressure	☐ Self	☐ Family
➢ Lung Problems	☐ Self	☐ Family
➢ Devel./growth problems	☐ Self	☐ Family
➢ Cancer	☐ Self	☐ Family
➢ Tumors	☐ Self	☐ Family
➢ Infectious Disease	☐ Self	☐ Family
➢ Hepatitis	☐ Self	☐ Family
➢ Tuberculosis	☐ Self	☐ Family
➢ Kidney problems	☐ Self	☐ Family
➢ Repeated infections	☐ Self	☐ Family
➢ Ulcer/Stomach problems	☐ Self	☐ Family
➢ Depression	☐ Self	☐ Family
➢ Mental illness	☐ Self	☐ Family
➢ Diabetes/high blood sugar	☐ Self	☐ Family
➢ Hypoglycemia/low blood sugar	☐ Self	☐ Family
➢ Skin disease	☐ Self	☐ Family
➢ Lupus	☐ Self	☐ Family
➢ Fibromyalgia	☐ Self	☐ Family
➢ Immune Disorders	☐ Self	☐ Family
➢ Auto Immune Disorders	☐ Self	☐ Family
➢ Gout	☐ Self	☐ Family
➢ Spinal Cord Injury	☐ Self	☐ Family
➢ Multiple Sclerosis	☐ Self	☐ Family
➢ Muscular Dystrophy	☐ Self	☐ Family
➢ Parkinson's Disease	☐ Self	☐ Family
➢ Seizures/Epilepsy	☐ Self	☐ Family
➢ Asthma	☐ Self	☐ Family
➢ Stroke/TIA	☐ Self	☐ Family
➢ Head Injury	☐ Self	☐ Family
➢ Thyroid Problems	☐ Self	☐ Family

Have you had any of the following symptoms in the past year?

- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Cough
- ☐ Hoarseness
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Blackouts
- ☐ Coordination problems
- ☐ Weakness (arms/legs)
- ☐ Loss of balance
- ☐ Difficulty walking
- ☐ Vision problems
- ☐ Joint pain or swelling
- ☐ Back pain
- ☐ Pain at night
- ☐ Fatigue
- ☐ Difficulty sleeping
- ☐ Loss of appetite
- ☐ Nausea/vomiting
- ☐ Difficulty swallowing
- ☐ Bowel problems
- ☐ Weight loss/gain
- ☐ Urinary problems
- ☐ Fever/chills/sweats
- ☐ Headaches
- ☐ Hearing problems
- ☐ Lumps/lesions
- ☐ Changes in skin/moles

Name:

General Medical Information

Please rate your health: ☐Excellent ☐Good ☐Fair ☐Poor
Do you currently use tobacco? ☐Yes ☐No If yes: ☐Cigarettes ___pks/day ☐Cigars__/day ☐Chew__/day
Have you ever used tobacco in the past? ☐Yes ☐No When did you quit? __/__/__
Do you drink alcohol? ☐Yes ☐No If yes, How many days a week do you drink? __days/wk How many per day? __/day
Do you use illegal drugs? ☐Yes ☐No If so, what drugs do you use and how often?
Do you currently use eyeglasses or hearing aids? ☐Yes ☐No Please specify?

Functional Status

Are you currently having difficulty moving/rolling in bed? ☐Yes ☐No
Are you currently having difficulty moving from laying down to sitting? ☐Yes ☐No
Are you currently having difficulty moving from sit to stand? ☐Yes ☐No
Are you currently having difficulty with transfers (from bed to chair, getting into car, or tub, ect.)? ☐Yes ☐No
Are you able to walk on even ground? ☐Yes ☐No
Are you having difficulty walking on uneven ground? ☐Yes ☐No
Are you having difficulty climbing stairs? ☐Yes ☐No
Are you able to tolerate Activities of daily living (dressing, grooming, housework)? ☐Yes ☐No If no, please specify what activities you are having difficulty with:

Are you able to tolerate work activities? ☐Yes ☐No If no, please specify what activities you are having difficulty with:

Are you having difficulty with any recreational activities? ☐Yes ☐No If yes, please specify what activities your having difficulty with:
What recreational activities/hobbies do you engage in? Please list:
Do you exercise on a regular basis? ☐Yes ☐No If so, how often and how long?

Pain Assessment

√ What area is the main focus of your pain?
On a scale of 1-10 (1-least 10severe) please rate your pain: at rest( ) with activity ( ) at worst ( ).
Quality of pain: ☐Sharp ☐Dull ☐Burning ☐Electrical ☐Cramping Is the pain: ☐Localized ☐Radiating
What makes pain worse?
What makes pain better?
√ Is there another area of pain that is also a major focus?
On a scale of 1-10 (1-least 10severe) please rate your pain: at rest( ) with activity ( ) at worst ( )
Quality of pain: ☐Sharp ☐Dull ☐Burning ☐Electrical ☐Cramping. Is the pain: ☐Localized ☐Radiating
What makes the pain worse?
What makes the pain better?

Medications

Are you currently on any pain medication? ☐None ☐Prescription ☐Non-Prescription (Please check any that apply):
☐Advil/Aleve ☐Antacids ☐Ibuprofen/Naproxen ☐Herbal Supplements ☐Asprin ☐Decongestants ☐Antihistamines
☐Tylenol ☐Other:
Please list medications that you are currently taking:

Do you have any drug allergies? ☐Yes ☐No Please list:

Workers Compensation

Please fill out this section ONLY if you are claiming this injury/illness as Workers Compensation

Is this problem due to injury/illness that you received at work? ☐Yes ☐No
Date of injury/illness: __/__/__ (required for workers compensation)
Has your employer been notified of your illness/injury? ☐Yes ☐No
What was the last date you worked? __/__/__ (Leave blank if you are still working)
Are there any other physicians that are treating you for this injury/illness other than the physician that referred you here? Please list:
Please describe briefly how your injury occurred:
Are you currently working? ☐Yes ☐No if yes, do you have any restrictions? Please list:
I have answered the above questions to the best of my knowledge.

Signature X_____ **Date**__/__/__ **WitnessSignature** X_____ **Date**__/__/__