

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 (Referring 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: _____

Please describe briefly how the injury may have occurred: _____

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: _____

Workers Compensation

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

Is this problem due to an injury/illness that you received at work? Yes No

Date of injury/illness: ____/____/____ (required for workers comp)

Has your employer been notified of your injury/illness? 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:

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, etc.)? Yes No

Are you able to ambulate on even terrain? Yes No

Are you having difficulty ambulating on uneven terrain? 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 you are 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 10 severe) 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?

✓ Is there another area of pain that is also a major focus?

On a scale of 1-10 (1-least 10 severe) 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 Aspirin Decongestants Antihistamines Tylenol Other:

Please list medications that you are currently taking:

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

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 eye glasses or hearing aids? Yes No Please specify?

I have answered the above questions to the best of my knowledge.

Signature _____ Date ____/____/____ Witness Signature _____ Date ____/____/____