OUTPATIENT HISTORY QUESTIONNAIRE

Patient Name: _____ Date: _____

With respect to the condition that brings you to therapy, how would you describe yourself now compared to immediately after your condition occurred? *(Please circle the appropriate number.)*

-5 -4 -3 -2 -1 0 1 2 3 4 5

Very much worse — Unchanged — Completely recovered

Please check if you have ever had:

- □ Arthritis/gout
- □ Broken bones/fractures
- □ Osteoporosis
- □ Blood disorders
- □ Circulation/vascular problems
- □ Heart problems
- □ High Blood Pressure
- □ Stroke
- □ Infectious disease
- □ Low blood sugar/hypoglycemia
- □ Head injury
- □ Metal implants
- □ Neurological problems
- □ (Parkinsons, Multiple Schlerosis etc)
- □ Seizures/epilepsy
- □ Thyroid problems
- □ Diabetes/high blood sugar
- □ Other: _____
- □ Kidney problems
- □ Repeated infections
- □ Ulcers/stomach problems
- □ Skin diseases
- □ Depression
- □ Pacemaker
- □ Lung problems
- □ Cancer

Please explain any box checked above: _____

_____

Within the past year, have you had any of the following symptoms? (check all that apply)

- □ Chest pain
- □ Heart palpitations
- □ Cough
- □ Hoarseness
- □ Shortness of breath
- □ Dizziness or blackouts
- □ Difficulty swallowing
- □ Loss of balance/falls
- □ Difficulty walking
- □ Joint pain or swelling
- □ Pain at night
- □ Difficulty sleeping
- □ Loss of appetite
- □ Nausea/vomiting
- □ Bowel problems
- □ Weight loss/gain
- □ Urinary problems
- □ Fever/chills/sweats
- □ Headaches
- □ Hearing problems
- □ Vision problems
- □ Coordination problems
- □ Weakness in arms or legs

□ Other: _____

Have you ever had any surgery? _____ If yes, please describe and include dates: _____

_____

Have you had any testing done recently (x-rays, MRI blood tests, etc)? If so, what were the results?

_____

Have you had any illnesses within the last 3 weeks (ie colds; influenza; bladder or kidney infection)?

_____

Do you have discomfort, shortness of breath, or pain with exercise? _____

Do you smoke? _____ If so, how much? _____

List any current medications you are taking both prescription and non prescription:

_____

_____

_____

(Continued on Back)

OUTPATIENT HISTORY QUESTIONNAIRE (cont)

Patient Name: _____ Date: _____

List any allergies, including medications: _____

_____

Are you receiving Home Health Care Services at this time?_____

Do you have any sores that have not healed or any changes in size, shape, or color of a wart or mole?

_____

What is your occupation? /or retired from? _____

Do you engage in regular exercise? _____ What type and how often? _____

Please describe the problem(s) for which you seek outpatient treatment: _____

_____

When did the problem(s) begin (date)? _____

Have you ever had the problem(s) before? If yes, please describe_____

_____

Have you ever received therapy or any other treatment for this condition? What type and where?

_____

Do you use any special supports or devices: _____

_____

Has the current condition for which you are seeking therapy affected your ability to perform any of the following? Please check all that apply.

□ Personal care (bathing, dressing, grooming)
□ Getting in/out of bed, chair, car
□ Sleep
□ Standing
□ Climbing stairs
□ Running/jumping
□ Family/home responsibilities
□ Lifting, bending, kneeling, stooping
□ Pushing/pulling
□ Sitting
□ Walking
□ Driving
□ Leisure/recreational activities
□ Other: _____

How do you learn best? Reading Listening Demonstration Other: _____

Do you have any cultural or religious beliefs that might affect your care? _____

_____

In case of emergency, who should be notified? (Please include phone #'s) _____

_____

Patient Signature: _____

Administrative Designee Accepting Patient for Admission: _____