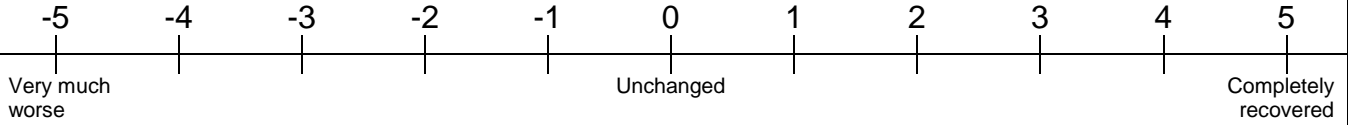




OUTPATIENT HISTORY QUESTIONNAIRE

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.)



Please check if you have ever had:

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

Please explain any box checked above: _____

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

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

- | | |
|--|---|
| <input type="checkbox"/> Personal care (bathing, dressing, grooming) | <input type="checkbox"/> Lifting, bending, kneeling, stooping |
| <input type="checkbox"/> Getting in/out of bed, chair, car | <input type="checkbox"/> Pushing/pulling |
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Climbing stairs | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Running/jumping | <input type="checkbox"/> Leisure/recreational activities |
| <input type="checkbox"/> Family/home responsibilities | <input type="checkbox"/> 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: _____