MEDICAL HISTORY

QUESTIONNAIRE

NORTHEAST REHABILITATION HOSPITAL NETWORK

PATIENT NAME: _____ **BIRTHDATE:** _____ **DATE:** _____

Emergency Contact: _____ Phone:_____

Referring MD:_____ Phone:_____

to be filled out by your Therapist

MR #

PRECAUTIONS:

__cardiac __seizure

__hypertension __diabetes

__internal fix __cancer

__weight bearing __pregnancy

__coumadin __pacemaker

__other:_____

Therapist initials

Please answer the following questions

1) What was the onset date of your present condition?(month/day/year) _____

2) Do you have allergies? (i.e. medication, latex, bee stings) ..... yes no

If yes, please explain: _____

_____

3) Are you currently taking medication? ..... yes no

If yes, please complete the following:

MEDICATION	DOSE/FREQUENCY	REASON FOR TAKING

* Per patient report

4) Are you currently receiving medical care other than for your primary condition? ..... yes no

If yes, please explain: _____

_____

5) Have you ever been hospitalized for a surgical procedure or other serious illness? ..... yes no

If yes, please explain: _____

_____

6) Are you currently taking herbal remedies? ..... yes no

If yes, *please explain:* _____

_____

7) Do you experience pain? ..... yes no

If yes, please circle the number that represents your *average daily pain:*

(no pain)0----1----2----3----4----5----6----7----8----9----10(worst)

moderate

8) What are your therapy goals? (what do you hope to achieve) _____

_____

(please turn over to complete page 2 and sign your name)

9) Have you ever fractured (broken) a bone? [yes/no] Do you have internal fixation (I.e. pins, rod, screws)……. yes no

If yes, please explain: _____

10) Do you exercise on a regular basis? ..... yes no

If yes, please explain: _____

11) Do you have weakness in your body? ..... yes no

If yes, please explain: _____

12) Do you have altered sensations in your body? (i.e. numbness, tingling, burning) ..... yes no

If yes, please explain: _____

13) Have you recently experienced loss of appetite, anxiety/mood changes, or significant weight gain/loss?..... yes no

If yes, please explain: _____

14) Are you experiencing any social or emotional difficulties at home/work that you feel we should be aware of? yes no

If yes, please explain: _____

15) Are you experiencing any abuse at home? …….. yes no

If yes, please explain: _____

16) Do you live alone? ……. yes no

If yes, who can provide care if needed? _____

17) *Do you have obstacles in/out of your home? (stairs, clutter, uneven flooring, etc) ……* yes no

If yes, what _____

Have you ever been diagnosed with or are you currently experiencing any of the following conditions? (please check yes or no for each condition)

circle	yes	no		yes	no		yes	no
blood pressure (high/low)			thyroid disease			osteoporosis		
heart disease			Leukemia			glasses/contacts		
cardiac pacemaker			hepatitis			cataracts/glaucoma		
angina/chest pain			tuberculosis			blindness		
mitral valve prolapse			shortness of breath			other visual impairment		
heart attack			emphysema			loss of balance		
heart murmur			asthma/bronchitis			incontinence		
diabetes			other respiratory problems			pelvic pain		
CVA/stroke			skin rash/open wounds			chronic headaches		
cancer			psoriasis/eczema			hearing loss		
seizures			swelling			hearing aide(s)		
anemia			stomach troubles/ulcer			dizziness/vertigo		
liver disease			arthritis			pregnancy		
kidney disease			joint replacement/implant			Other:_____		
fibromyalgia			neurological disorders					

If "yes" to any of the above, please explain: _____

Therapist initials

* _____

Patient/Guardian Signature ***Date***