NORTHEAST REHABILITATION HOSPITAL NETWORK

Outpatient Therapy Medical History Questionnaire

Rev 9/17

PATIENT NAME: _____

BIRTHDATE: _____

DATE: _____

Please Answer The Following Questions:

1) Injury/Onset Date: _____

2) Surgery Performed: No □ Yes □ Date of Surgery: _____ Type of Surgery: _____

3) Prior Hospitalization: No □ Yes □ Dates of Hospitalization: _____

4) How did you injure yourself? _____

5) What is your primary complaint/concern? _____

6) Do you experience pain? No □ Yes □

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 pain)

What makes your pain worse? _____

What makes your pain better? _____

7) Have you recently experienced loss of appetite, anxiety/mood changes, or significant weight gain/loss?
No □ Yes □ If yes, please explain: _____

8) Are you experiencing any social or emotional difficulties at home/work that we should be aware of?
No □ Yes □ If yes, please explain: _____

9) Are you experiencing any abuse at home?
No □ Yes □ If yes, please explain: _____

10) Please check off any of the following medical issues that may apply to you:

□ Alzheimer's
□ Cardiovascular Disease
□ Cauda Equina Syndrome
□ Cerebral Vascular Accident (Stroke)
□ Current Infection
□ Diabetes Type 1
□ Diabetes Type 2
□ Fibromyalgia
□ Fracture or Suspected Fracture
□ High Blood Pressure
□ History of Cancer
□ Huntington's
□ Immunosuppression
□ Lupus
□ Muscular Dystrophy
□ Obesity
□ Osteoarthritis
□ Parkinson's
□ Rheumatoid Arthritis
□ Traumatic Brain Injury

□ Other: □ Pregnant □ Joint Replacement/Implant □ Seizures □ Pacemaker

11) Do you have any allergies? (i.e. medication, latex) No □ Yes □ _____

12) Please list current medications, herbals or vitamins or provide med list:

Medication	Dose/Frequency	Reason for Taking

13) What do you want to achieve by coming to therapy? What are your goals? _____
_____

Patient or Guardian Signature: _____ Date:_____ Time: _____

Clinician Signature/Print: _____ Date:_____ Time: _____