Outpatient Therapy Medical History Questionnaire

Rev. 07/21

Patient Name: ______________________________
Preferred Name to be addressed: ______________________________
Date of Birth: ______________________________
Preferred Language: ______________________________
Birth Gender: □ Male □ Female □ Choose not to disclose
Gender Identity: □ Male □ Female □ Nonbinary □ Choose not to disclose

1) What is your primary complaint/concern? ______________________________

2) Injury/Onset Date: ______________________________

3) Surgery Performed: □ No □ Yes Date of Surgery: ____________ Type of Surgery: ______________________________

4) Related Hospitalization: □ No □ Yes Dates of Hospitalization: ______________________________

5) Have you fallen in the past year? □ No □ Yes If Yes, how frequent have you fallen? ______________________________

6) Do you experience pain? □ No □ Yes 0 = None 5 = Moderate 10 = Extreme

Pain at worst 0----1----2----3----4----5----6----7----8----9---10
Pain current 0----1----2----3----4----5----6----7----8----9---10
Pain at best 0----1----2----3----4----5----6----7----8----9---10

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: ________