Providence St. Mary Medical Center Outpatient Rehabilitation
Health History Questionnaire

Name:_____ Age:____ Date of Birth:_____

Medications/Supplements/Herbal **Reason for taking**

Allergies: **Reaction:**

1: Describe the current problem that brought you here:

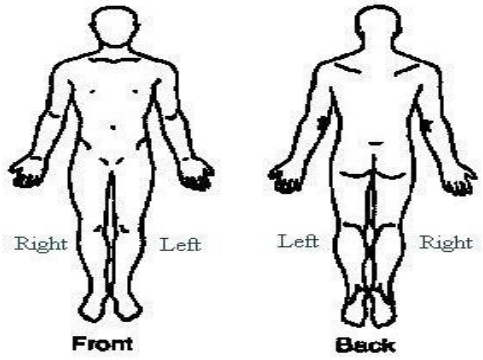
2. When did your problem first begin? _____ months ago or _____ years ago.

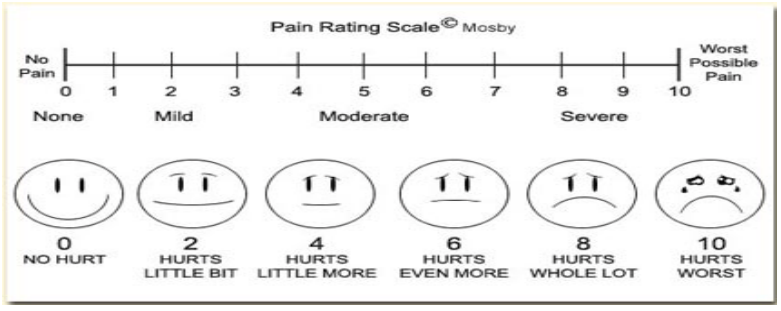
3. Was your first episode of the problem related to a specific incident? Yes No

4. Since that time is it: staying the same _____getting worse _____ getting better _____.

5. Describe previous treatment/exercises you have had. _____

6.





Now _____ Worst _____ Best _____

Indicate where your pain is located and what type of pain you feel now. Do not indicate areas of pain which are not related to your Present pain. KEY: /// Stabbing XXX Burning OOO Pins and needles === Numbness

7. Activities/Events that cause or aggravate your symptoms. Check all that apply.

____ Sitting greater then _____ minutes
____ Walking greater then _____ minutes
____ Standing greater then ____ minutes
____ Changing positions (ie –sit to stand)
____ Light activity (light housework)
____ Vigorous activity/exercise (run/weight lift/jump)
____ Sexual activity
____ Cough/sneeze/straining
____ Laughing/yelling
____ Lifting/bending
____ Cold weather
____ Triggers – running water/key in door
____ Nervousness/anxiety
____ No activity affects the problem
____ Other, please specify _____

8. What relieves your symptoms? _____

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9. To what degree has your life style changed because of this problem?

None	Mild	Moderate	Severe		
____	____	____	____	Social activities (ie hobbies) specify	_____
____	____	____	____	Weight change , specify	_____
____	____	____	____	Physical activity, specify	_____
____	____	____	____	Work, specify	_____
____	____	____	____	Other	_____

10. What are your treatment goals? _____

Health History: Date of last physical exam? _____ Tests performed _____

Since the onset of your current symptoms have you had:

Y/N	Fever/chills	Y/N	Malaise (unexplained tiredness)
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/Sweats
Y/N	Change in bowel or bladder functions	Y/N	Numbness/Tingling
Y/N	Other/describe _____		

General Health: Excellent Good Average Fair Poor Activity Restrictions? _____
Occupation _____ Hours Worked _____ On disability or leave _____
Mental Health: Current level of stress: High _____ Med _____ Low _____ Current psych therapy? Y/N

Have you ever had any of the following conditions or diagnoses? Circle all that apply.

Cancer	Stroke	Emphysema/Chronic Bronchitis
Heart Problems	Epilepsy/Seizures	Asthma
High Blood Pressure	Multiple Sclerosis	Allergies-list below
Ankle swelling	Head Injury	Latex Sensitivity
Anemia	Osteoporosis	Hypothyroid/Hyperthyroid
Low Back Pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug Problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress Fracture	Irritable Bowel Syndrome
Depression	Rheumatoid Arthritis	Hepatitis HIV/AIDS
Anorexia/bulimia	Joint Replacement	Sexually Transmitted Disease
Smoking History	Bone Fracture	Physical or Sexual Abuse
Vision/Eye problems	Sports Injuries	Raynauds (cold hands and feet)
Hearing loss/problems	TMJ/neck pain	Pelvic Pain

Other/Describe_____

Date Surgical/Procedure History

_____	Y/N Surgery for your back pain/Spine	_____ Y/N	Surgery for your bladder/prostate
_____	Y/N Surgery for your brain	_____ Y/N	Surgery for your bones/joints
_____	Y/N Surgery for your female organs	_____ Y/N	Surgery for organs in your abdominal region

Other/Describe: _____

Personal Habits

Do you exercise? Y/N How much? _____ **Use Alcohol Y/N How much? _____**
Do you use caffeine? Y/N How much? _____ **Use Tobacco Y/N How much? _____**
How much water do you drink? _____ **Recreational drug use? Y/N How much _____**

Home Environment

Live with _____
House/ Mobile Home/ Apartment/ Assisted Living/ Foster Care/ Skilled Nursing Facility (circle one)
Single Level/ Multi Level Stairs Y/N Handrails Y/N

_____

PATIENT SIGNATURE I have completed this form to the best of my knowledge DATE

[ ] Therapist has reviewed with patient _____