

HEALTH HISTORY INFORMATION:

The following is a list of common health problems. Please indicate those problems you currently have or have had in the past and include the approximate date. **Check only those that apply to you.**

Medical Problem	Problems You Have or Had in the past		Medical Problem	Problems You Have or Had in the past	
Abdominal Pain/Problems	<input type="checkbox"/>	Date: _____	High blood pressure	<input type="checkbox"/>	Date: _____
Alcohol or Drug Abuse	<input type="checkbox"/>	Date: _____	Intravenous Drug Use	<input type="checkbox"/>	Date: _____
Anemia or other Blood Disease	<input type="checkbox"/>	Date: _____	Joint Replacement	<input type="checkbox"/>	Date: _____
Angina (chest pain)	<input type="checkbox"/>	Date: _____	Kidney or Liver Disease	<input type="checkbox"/>	Date: _____
Anxiety, Depression, or Panic Attacks	<input type="checkbox"/>	Date: _____	Lung disease	<input type="checkbox"/>	Date: _____
Arthritis	<input type="checkbox"/>	Date: _____	Multiple Sclerosis (M.S.)	<input type="checkbox"/>	Date: _____
Asthma	<input type="checkbox"/>	Date: _____	Muscle, Bone, or Joint Injury	<input type="checkbox"/>	Date: _____
Bowel or Bladder Irregularities	<input type="checkbox"/>	Date: _____	Osteoporosis	<input type="checkbox"/>	Date: _____
Cancer	<input type="checkbox"/>	Date: _____	Pacemaker	<input type="checkbox"/>	Date: _____
Carpal Tunnel Syndrome	<input type="checkbox"/>	Date: _____	Parkinson's disease	<input type="checkbox"/>	Date: _____
Circulatory problems	<input type="checkbox"/>	Date: _____	Persistent fever	<input type="checkbox"/>	Date: _____
Congestive Heart Failure	<input type="checkbox"/>	Date: _____	Phlebitis/blood clots	<input type="checkbox"/>	Date: _____
Diabetes	<input type="checkbox"/>	Date: _____	Pregnant _____ weeks	<input type="checkbox"/>	Date: _____
Epilepsy or Seizure Disorder	<input type="checkbox"/>	Date: _____	Psychological treatment	<input type="checkbox"/>	Date: _____
Fainting, Dizziness, or Vertigo	<input type="checkbox"/>	Date: _____	Skin disease	<input type="checkbox"/>	Date: _____
Fibromyalgia	<input type="checkbox"/>	Date: _____	Stress	<input type="checkbox"/>	Date: _____
Fractures/broken bones	<input type="checkbox"/>	Date: _____	Stroke/mini stroke	<input type="checkbox"/>	Date: _____
Frequent falls*	<input type="checkbox"/>	Date: _____	Thyroid	<input type="checkbox"/>	Date: _____
Gastrointestinal problems	<input type="checkbox"/>	Date: _____	TMJ	<input type="checkbox"/>	Date: _____
Gout	<input type="checkbox"/>	Date: _____	Tobacco Use	<input type="checkbox"/>	Date: _____
Headache or migraines	<input type="checkbox"/>	Date: _____	Tumors	<input type="checkbox"/>	Date: _____
Hearing problems (loss, aids)	<input type="checkbox"/>	Date: _____	Urinary Tract Infection	<input type="checkbox"/>	Date: _____
Heart attack	<input type="checkbox"/>	Date: _____	Unexplained weight loss	<input type="checkbox"/>	Date: _____
Heart disease	<input type="checkbox"/>	Date: _____	Use of Immunosuppressive Drugs	<input type="checkbox"/>	Date: _____
Heart surgery	<input type="checkbox"/>	Date: _____	Vision problem (loss, blurring, glasses, etc.)	<input type="checkbox"/>	Date: _____
Other:			Last Visual Exam:	Date: _____	

* If you indicated Frequent falls, how many have you have had in the last year and please describe any injuries related to falls:

Have you had a physical examination by your doctor in the past year? Yes No

Comments: _____

PLEASE LIST ANY MAJOR SURGERIES/HOSPITALIZATIONS:

_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____

PLEASE LIST ANY KNOWN ALLERGIES:

PLEASE LIST ALL MEDICATIONS (PRESCRIPTION, OVER THE COUNTER, HERBAL) WHICH YOU ARE CURRENTLY TAKING:

SINCE THE ONSET OF YOUR PROBLEM, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

- | | | |
|-------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Balance difficulties | <input type="checkbox"/> Pain at rest | <input type="checkbox"/> Tingling, numbness, or loss of feeling |
| <input type="checkbox"/> Blurred or double vision | <input type="checkbox"/> Pain with exercise/exertion | <input type="checkbox"/> Tremors (shaking) |
| <input type="checkbox"/> Bowel/bladder habit changes | <input type="checkbox"/> Pain unrelieved by rest or movement | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Calf pain with exercise | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Unusual weakness or fatigue |
| <input type="checkbox"/> Chest pain, pressure, or tightness | <input type="checkbox"/> Speech pattern changes | <input type="checkbox"/> Wound that does not heal |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Swallowing difficulties | <input type="checkbox"/> Walking difficulties |
| <input type="checkbox"/> Fainting or "black outs" | <input type="checkbox"/> Swollen hands, feet, ankles or legs | <input type="checkbox"/> Other (please explain): _____ |

LIVING ENVIRONMENT

Do you have help at home? Yes (please specify): _____ No

Are you having any difficulties with managing your activities of daily living or personal matters? Yes No

What type of residence? Private Home or Condominium Private Apartment Assisted Living
 Personal Care Home Group Home Other: _____

Does your home have: (check all that apply)

Stairs - no railing Stairs with railing Elevator Ramp(s) Stair glide Other: _____

Do you own/use any of the following? (please check all that apply)

Crutches Cane (quad or straight) Walker Walker with wheels
 Wheelchair (manual) Wheelchair (powered) Scooter (motorized) Other: _____

EMPLOYMENT/WORK

What is your current work status? Check the **one** category that best describes your current work status.

- | | |
|-------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> Work Regular Duty – Full Time | <input type="checkbox"/> Retired (Not due to health status) |
| <input type="checkbox"/> Work Regular Duty – Part Time | <input type="checkbox"/> Plan to Retire (please specify: _____) |
| <input type="checkbox"/> Work Light Duty/Modified Position – Full Time | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> Work Light Duty/Modified Position – Part Time | <input type="checkbox"/> Homemaker (Not working outside the home) |
| <input type="checkbox"/> Temporarily Unable to Work Due to Health Status | <input type="checkbox"/> Student (Not currently working) |
| <input type="checkbox"/> Permanently Unable to Work or Retired Due to Health Status | <input type="checkbox"/> Caregiver in home environment |

Occupation: _____

VOCATIONAL COUNSELING SERVICES

Are you concerned about your ability to return to work? Yes No
Would you like a consultation with a Vocational Counselor? Yes No

I, the undersigned, state that I have answered this questionnaire to the best of my knowledge.

Patient Signature _____
Date

Thank you for taking the time to provide us with this valuable information. It will help us to better serve you.

The following is to be completed by the Therapist

I have reviewed the Past Medical History and have made comments and/or referrals, when applicable.

Therapist Signature: _____ **Date:** _____