INSPIRE Physical Therapy & Wellness

Print Name:	
How did you hear about our clinic?	
Date of Birth:	Today's Date

Rehabilitation Medical History Questionnaire

PLEASE CHECK YES OR NO IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Heart Attack / heart disease			Respiratory problems		
Chest pains			Nervous / emotional conditions		
Diabetes			Hernia		
Insulin			Asthma / Pneumonia / Tuberculosis		
Shortness of breath			Jaundice		
Varicose veins / artery disease			Hepatitis		
Heart murmur / abnormal heart beat			Gall bladder problems		
High / Low blood pressure			Injuries to back, legs, arms & joints		
Thyroid problems			A.I.D.S.		
Anemia			Alcohol Abuse		
Osteoarthritis			Cancer – Location:		
Rheumatoid arthritis			Chemical Dependency		
Osteoporosis			*Head injury		
Bowel / bladder problems			*Fainting spells		
Abnormal chest x-ray			*Neurological Deficits (CVA, TIA, MS ETC.)		
Pregnancy			*Fractures		
Kidney disease			*Epilepsy / Seizures		

DO YOU NEED ASSISTANCE WITH ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Bathing			Eating		
Dressing			Swallowing		
Toileting			*Mobility / gait		
Communication of Needs			*Balance		

WITHIN THE LAST THREE MONTHS – HAVE YOU NOTICED ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Choking with meals			Inability to follow directions		
Nausea, vomiting, diarrhea			Nutritional support at home		
Eating less than 50% normal			Activities of daily living problems		
Weight loss greater than 10 lbs. in 1 month			Interference of oral intake		
Chewing / swallowing problems			*Decline in walking		
Food allergies / restrictions			*Balance problems		
Vision problems related to stroke			*Dizziness episodes		

OTHER MEDICAL CONDITIONS: _____

_____

LIST ALL SURGERIES OR INVASIVE PROCEDURES: _____

_____

INSPIRE Physical Therapy & Wellness

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Date of Birth: _____

Rehabilitation Medical History Questionnaire

LIFESTYLE: □ Active □ Sedentary (check one) CHOLESTEROL: □ Normal □ High (check one)

SMOKE TOBACCO: □ Yes □ No (check one) PACKS PER DAY: _____

DO YOU FEEL SAFE AT HOME? □ Yes □ No (check one)

ARE YOU IN A RELATIONSHIP IN WHICH YOU ARE BEING HIT, KICKED, SLAPED OR OTHERWISE HURT: □ Yes □ No (check one)

WHAT IS YOUR OCCUPATION? _____

ARE YOU CURRENTLY OUT OF WORK BECAUSE OF THIS PROBLEM? □ Yes □ No (check one)

HAND DOMINANCE? □ RIGHT HANDED □ LEFT HANDED (check one)

*HAVE YOU HAD ANY RECENT FALLS? □ Yes □ No (check one)

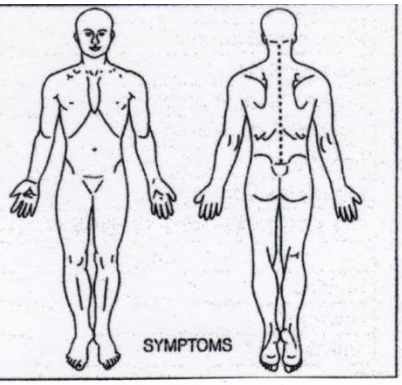
PLEASE RATE YOUR PAIN / SYMPTOMS: 0 = No Pain 10 = Worst pain possible

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

IF YOU HAVE PAIN, PLEASE CHECK THE WORD(S) BELOW THAT BEST DESCRIBE YOUR PAIN:

☐ Pulsing	☐ Tingling	☐ Aching	☐ Intense
☐ Throbbing	☐ Shooting	☐ Dull	☐ Exhausting
☐ Pounding	☐ Sharp	☐ Sore	☐ Miserable
☐ Quivering	☐ Burning	☐ Tender	☐ Nauseating

MARK THE LOCATION(S) OF YOUR SYMPTOMS ON THE BODY PICTURES TO THE RIGHT



PLEASE LIST 3 PERSONAL GOALS YOU WISH TO ACHIEVE WITH THIS THERAPY PROGRAM: (For example: decrease pain, return to work, return to sports, recreation, work about the house, etc.)
1.
2.
3.

WHAT MAKES YOUR PAIN BETTER? _____

WHAT MAKES YOUR PAIN WORSE? _____

Patient/Rep Signature: _____ Date: _____ Time: _____

TO BE COMPLETED BY THERAPIST

I certify that I have reviewed the preceding health information with the patient:

Therapists' Signature: _____ Date:_____

Time:_____

***Fall Risk?** □ Yes □ No

Medication Verification

Are you allergic to any medications, products or foods? □ No □ Yes If yes, please complete the box below:

ALLERGIC TO:	REACTION(S)	ALLERGIC TO:	REACTION(S)	ALLERGIC TO:	REACTION(S)

LIST BELOW ALL OF THE PATIENT'S HOME MEDICATIONS INCLUDING OTC AND ALTERNARIVE MEDS

Please do not use abbreviations

Source of Medication list: (check all used)

□ Patient medication list
□ Patient/Family recall
□ Pharmacy _____
□ Primary care physician list / PCHIS
□ Previous discharge paperwork
□ Medication Administration Record from facility
□ Other: _____

□ Pregnant? □ Breastfeeding?

					Post-Procedure	
MEDICATION NAME (WRITE LEGIBLY)	DOSE (mg, mcg)	ROUTE (PO, GT, Sub-Q, IV)	HOW OFTEN	LAST DOSE DATE/TIME	Cont	Stop