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.现在 _______ 最糟糕 _______ 最好 ________

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

8. What relieves your symptoms? ____________________________________________
9. To what degree has your lifestyle 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
Sacrococcygeal 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 _________________________________