Ascension

Outpatient Rehabilitation
History Form

Identifying Information

Name: _____ DOB: _____

Primary Care Physician: _____Cell Phone Number: _____

History

What is your reason for coming to therapy today? _____

_____

When and how did this problem begin? _____

_____

Have you RECENTLY noted any of the following (check all that apply)?

- ☐ Changes in bowel or bladder function
- ☐ Shortness of breath
- ☐ Nausea/vomiting
- ☐ Difficulty maintaining balance while walking
- ☐ Fever/chills/sweats
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Recent memory loss
- ☐ Weight loss/gain
- ☐ Fainting

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Cancer
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Asthma
- ☐ Pacemaker
- ☐ Osteoporosis
- ☐ Chemical dependence
- ☐ Rheumatoid arthritis
- ☐ Stroke
- ☐ Depression
- ☐ Anemia
- ☐ Lung problems
- ☐ Thyroid problems
- ☐ Parkinson's disease
- ☐ Diabetes
- ☐ Multiple sclerosis
- ☐ Kidney/liver problems
- ☐ Stomach ulcers
- ☐ Epilepsy
- ☐ Recent infections
- ☐ Other: _____

Do you smoke? YES NO _____PACKS/DAY **How much do you drink?** _____ Drinks per day

Do you have any allergies? **YES** **NO**

If yes, please list: _____

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES** **NO**

Limitations

Is there anything that your doctor told you not to do? **YES** **NO**

If yes, please explain: _____

History of present injury/previous injury

Have you previously had physical or occupational therapy? **YES** **NO**

Was it since January 1st of this calendar year? **YES** **NO**

Did the therapist come to your house? **YES** **NO**

Was it for the same problem? **YES** **NO**

If yes, please explain: _____

Are you currently receiving **OTHER** treatment for this problem (i.e. chiropractor, acupuncture, massage)? **YES** **NO**

If yes, please explain: _____

What kinds of tests have been done for your **current** problem?

☐ **MRI** ☐ **X-Ray** ☐ **CT SCAN** ☐ **Myelogram** ☐ **Blood work**

Other: _____

Results: _____

Have you been hospitalized in the past year? **YES** **NO**

If yes, when and for how long? _____

Do you have any metallic implants (i.e. ORIF, pain pump, pacemaker etc)? **YES** **NO**

If yes, please list: _____

Have you fallen in the last 6 months? **YES** **NO**

If yes, how many times and describe: _____

Medications

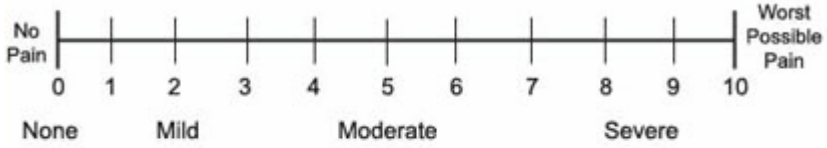
Are you taking any medications? **YES** **NO**

If yes, please list all medications you are currently taking (anticoagulants, steroids, blood pressure, etc.) If more than 4 medications, please bring in a list or photocopy of all medications.

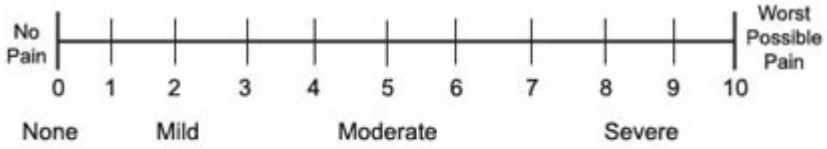
Medication	Dose	Direction for use

Pain

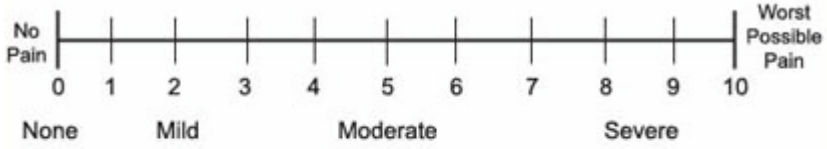
Pain at BEST: Rate your lowest pain level in the past 24 hours.
(Please circle one)

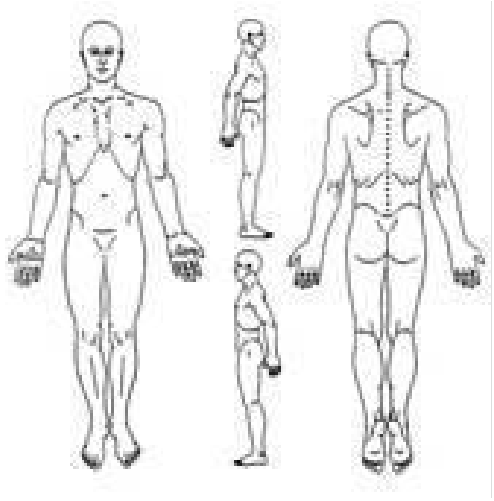


Pain CURRENTLY: Rate your level of pain at this time.
(Please circle one)



Pain at WORST: Rate your highest pain level in the past 24 hours.
(Please circle one)





Body Chart:
Please mark the location of your pain and type of pain on the chart:

Key:
X = sharp stabbing pain
O = dull achy pain
… = Numb/Tingling
//=Throbbing
-- = Burning

What are your goals as a result of attending therapy?_____

_____

_____

Patient Signature: _____ Date: _____/_____/_____

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