St. Dominic's
Outpatient Rehabilitation Services

Name: ______________________ **Date:** __________ **Time:** __________

What are your goals for therapy? ______________________________

Select any symptoms you have had in the past year.

- ☐ Bowel/Stomach Problems
- ☐ Chest Pain
- ☐ Coordination Problems
- ☐ Cough
- ☐ Difficulty Swallowing
- ☐ Difficulty Sleeping
- ☐ Difficulty Walking
- ☐ Dizziness/Fainting
- ☐ Excessive Thirst
- ☐ Feeling Downhearted
- ☐ Fever/Chills/Sweats
- ☐ Other ______________________________
- ☐ Frequent heart burn/indigestion
- ☐ Frequent headaches
- ☐ Hearing Problems
- ☐ Heart Palpitations
- ☐ Hoarseness
- ☐ Joint Pain/Swelling
- ☐ Loss of Appetite
- ☐ Loss of Balance/falling
- ☐ Nausea/Vomiting
- ☐ Numbness
- ☐ Pain at Night
- ☐ Prolonged Fatigue
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Shortness of Breath
- ☐ Stress/Tension
- ☐ Unusual lumps, growths or sore
- ☐ Urinary Problems
- ☐ Vision Problems
- ☐ Weakness in Arms/Legs
- ☐ Weight Loss/Gain
- ☐ Excessive worry, anxiety

Select any conditions/diagnoses that you have currently or in the past.

- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disorders
- ☐ Broken Bones/fractures
- ☐ Cancer
- ☐ Circulation/vascular problems
- ☐ COPD (chronic obstructive pulmonary)
- ☐ Deep vein thrombosis/PE
- ☐ Depression
- ☐ Developmental/Growth Problems
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Head Injury
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Infectious Disease (TB, hepatitis, shingles)
- ☐ Kidney/Liver Problems
- ☐ Low Back Pain
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Osteoporosis (thin bones)
- ☐ Whiplash/neck injury
- ☐ Osteoarthritis
- ☐ Parkinson Disease
- ☐ Recent Falls
- ☐ Peripheral Neuropathy
- ☐ Psychiatric Disorders
- ☐ Repeated Infections
- ☐ Seizures/Epilepsy
- ☐ Skin Diseases
- ☐ Stomach Problems/ulcers
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Vision Impairment
- ☐ HIV/AIDS
- ☐ Spasticity
- ☐ Other: __________

List any surgeries you have ever had: ______________________________

MEDICAL HISTORY QUESTIONNAIRE

bottom of patient label

Do you have any allergies? ☐ Foods________________________ ☐ Medications________________
☐ Latex ☐ Other____

List any prescription medicines you are currently taking.

____
____
____

List any non-prescription medications you are currently taking (including herbal supplements and vitamins).

____
____

Please rate your general health: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Have you had any major life changes in the past year? (ex: new baby, job change, death of a family member).
☐ No ☐ Yes (please list): ______________________________

Are you currently using tobacco? ☐ No ☐ Yes **Used in past?** ☐ No ☐ Yes Total years of tobacco use________
Cigarettes: # of packs per day _______ Cigars/Pipes: # per day_______ Smokeless Tobacco: # dips/chews per day _______

Do you currently drink alcohol? ☐ Yes ☐ No Number of days per week _______Average drinks per day __________

Select any exercise you do beyond normal daily activities and chores.

☐ Aerobics	☐ Gardening/Yard Work	☐ Skating	☐ Weightlifting
☐ Biking	☐ Golf	☐ Swimming	☐ Yoga/Pilates/TaiChi
☐ Boating	☐ Outdoor Activities	☐ Team Sports	☐ Tennis
☐ Bowling	☐ Running/Jogging	☐ Walking	☐ Other:__________

Select any leisure activities that you enjoy.

☐ Board Games	☐ Sewing	☐ Reading	☐ Other__________
☐ Cards	☐ Travel	☐ Computer	
☐ Needlework	☐ Woodworking	☐ Hunting	

With whom do you live? ☐ Alone ☐ Child ☐ Spouse ☐ Other: ______________
Do you have someone who can help you with daily activites? ☐ No ☐ Yes

Before your injury/illness did you have problems with walking, daily activities, leisure activities, or getting around your home? ☐ No ☐ Yes If yes, which activites?______________________________

Are you currently working?
☐ No ☐ Yes ☐ Full Time ☐ Part Time Position/Duties:______________________________

Are you having pain? ☐ No ☐ Yes **If yes , does the pain interfere with your ability to sleep, perform normal daily activities, chores, job, or social activities?** ☐ No ☐ Yes **Which activities?**____________________

Patient Signature	Time	Date	Therapist Signature	Time	Date

MEDICAL HISTORY QUESTIONNAIRE

bottom of patient label