Banner Health®

OUTPATIENT REHABILITATION SERVICES
MEDICAL HISTORY QUESTIONNAIRE

What condition, injury or surgery caused your need for therapy treatment? _____

_____

How and when did this occur/begin? _____

How does this affect your daily activities? _____

What are your goals for therapy? _____

Are you having pain? ❑ Yes ❑ No Are you having numbness/tingling? ❑ Yes ❑ No

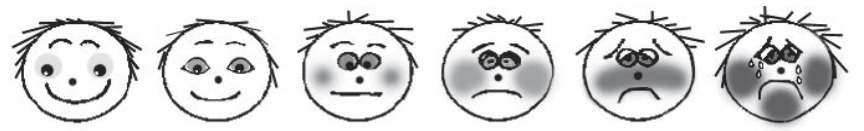
What increases your pain/symptoms? _____

What decreases your pain/symptoms? _____

Time of day when pain/symptoms are worse: _____

Do your pain/symptoms wake you up? ❑ Yes ❑ No

Rate your level of pain:
(Circle one)



Rate your health ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

Are you currently receiving medical care in the home? ❑ Yes ❑ No If yes, what type? _____

Are you currently receiving other therapy services? ❑ Yes ❑ No Type: _____

Have you had therapy in the past year? If yes, what were you seen for? _____

_____

Is there someone at home that can assist with your care? ❑ Yes ❑ No If no please explain:

_____

Do you have steps/stairs in your home? ❑ Yes ❑ No

Do you use a cane, walker or other assistive device? ❑ Yes ❑ No _____

Have you fallen in the past year? If yes, how many times? _____

Are you currently working? ❑ Yes ❑ No If no, when did you last work? _____

Occupation: _____ Job duties: _____

Do you participate in any regular hobbies, sports or exercise activities? ❑ Yes ❑ No

If yes, what type? _____

Primary Care Physician: _____

Banner Health®

OUTPATIENT REHABILITATION SERVICES
MEDICAL HISTORY QUESTIONNAIRE

Do you presently have any of the following: (Please mark Yes or No. If yes, please explain below.)

	Yes	No		Yes	No		Yes	No
Skin Disease			Anemia/Bleeding			Arthritis		
Back Trouble			Blood Clots/DVT			Cardiac/Heart problems		
Breathing Problems			Cancer			Pacemaker		
Diabetes			High Blood Pressure			Use orthotic/prosthetic		
Ear Trouble			Tuberculosis			Dizziness		
Eye Problems			Headaches			Epilepsy/Seizures		
Infection			Kidney Problems			Stroke		
Implants			Nausea/Vomiting			Vascular problems		
Musculoskeletal Problems			Swelling in hands/feet/joints			Bone Problems – fractures/ sprains		
Chest Pain			Depression			Osteoporosis		
Use Oxygen or Shortness of breath			Incontinence – bowel/bladder			Tobacco use QTY per day_____		
Head Injury			Spinal Cord Injury			Swallowing problems		

Please explain all *YES* answers: _____

_____

Other Medical History:_____

_____

Have you had any tests (i.e. x-rays/MRI) for this condition? ❑ Yes ❑ No If yes, what and where was it performed? _____

_____

Date:	Recent Surgeries, hospitalizations, or procedures:	Problems/Complications:

Please list current medication, including over the counter medications and herbal supplements

Medications:	For what?	**Medications:**	For what?

Do you have any of the following allergies? ❑ No allergies ❑ Drug ❑ Latex ❑ Food ❑ Tape ❑ Other

_____

Is there a possibility that you may be pregnant? ❑ Yes ❑ No If yes, due date: _____

Is there anything else you think we should know about? _____

_____

How do you best learn? ❑ Written ❑ Verbal ❑ Hands-on demonstration ❑ Other

Do you have difficulty with the following? ❑ Unable to understand/follow directions ❑ Hearing ❑ Speech ❑ Vision ❑ Language ❑ Writing ❑ Other ❑ No problem identified

Patient's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

8021
(05/2017)

Banner Health®

OUTPATIENT REHABILITATION SERVICES
MEDICAL HISTORY QUESTIONNAIRE

Please mark your area of pain.