MERCYHEALTH

Mercy-Tiffin Rehabilitation and Therapy
Rehab Services Patient History Questionnaire

In order for us to fully address all aspects of your problem, the following information is needed. Please take time to complete this form. Feel free to ask for assistance or clarification. Thank you!

NAME:_____ DATE:_____

PERSONAL

Do you speak and read English easily? ☐ Yes ☐ No
If No, what language do you use daily?_____
Are you 65 years of age or older? ☐ Yes ☐ No
Have you fallen in the last year? ☐ Yes ☐ No
(Therapist note: A YES to either question requires a Fall Risk Assessment)

HISTORY OF CURRENT COMPLAINT

1. What is the reason you are here for therapy?

_____

_____

2. How did this happen? (accident, fall, etc.)_____

_____

3. When did it start?
Date:_____
4. Have you had this problem before? ☐ Yes ☐ No
5. Have you had therapy for this problem before? ☐ Yes ☐ No
If YES When?_____ What Facility?_____ How many visits?_____

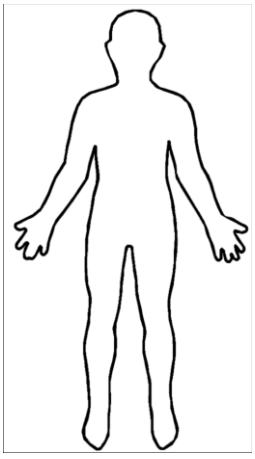
6. Has your doctor run any of the following tests for your current problem?
☐ X-Ray ☐ MRI ☐ CT ☐ EMG ☐ Vascular Studies ☐ Other:_____
7. Are you currently having pain or have you had pain in the recent past? ☐ Yes ☐ No
(If you answered YES to #7, please answer questions 8-14)
8. On the picture, shade in the areas where you feel pain.
9. On the picture, put an "X" on the area that hurts the most.
10. Please rate your pain by circling the one number that best describes your pain right now.

No Pain				Moderate Pain				Unbearable Pain		
0	1	2	3	4	5	6	7	8	9	10

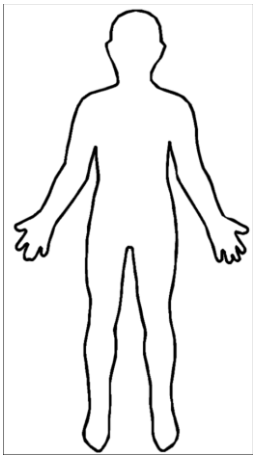
11. Please check all the words that describe your pain:

☐ constant ☐ intermittent
☐ dull ☐ sharp
☐ shooting ☐ stabbing
☐ burning ☐ aching
☐ numb ☐ other_____

FRONT



BACK



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12. What % of your day does pain interfere with your daily activities?_____
(i.e. 0% does not interfere at all, 100% interferes the ENTIRE day)

13. What makes your pain worse?_____

14. What makes your pain better?_____
(i.e. positions, heat, cold, medication)

15. Are you experiencing any of the following?

- ☐ Restlessness or twitching
- ☐ Perspiration
- ☐ Flushing
- ☐ Headache
- ☐ Stomachache
- ☐ Apprehension
- ☐ Trouble Sleeping
- ☐ Low energy or chronic fatigue
- ☐ Less comfortable with or avoid people
- ☐ Less talkative than usual
- ☐ Increased crying
- ☐ More pessimistic attitude of injury or failure
- ☐ Weight gain or loss of 10lbs or more
- ☐ Mood changes
- ☐ Bowel/Bladder Problems

16. What are your goals for therapy?_____
_____
_____

EMPLOYMENT INFORMATION

1. Employer_____ ☐ Self-Employed

Job Title_____ Shift_____
If you are off work due to present injury/illness, what was the last day you worked?_____
Is this injury job related? ☐ YES ☐ NO

2.Check those Items that currently apply to you:
☐ Full-Time ☐ Part-Time ☐ Homemaker ☐ Work with Restrictions ☐ Retired
☐ Not working due to this condition ☐ Unemployed ☐ Student ☐ Medical Leave
☐ Disability

3. Expected to return to work:_____

-continued-

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MEDICAL HISTORY

1. Have you had, or do you currently have, any of the following listed conditions?

☐ High Blood Pressure	☐ Heart Problems	☐ Pacemaker
☐ Panic Attacks	☐ Stroke	☐ Diabetes
☐ Gland Problems (thyroid)	☐ Arthritis	☐ Anxiety
☐ Cancer	☐ Lung Disease	☐ Circulation Problems
☐ Vision Problems	☐ Hearing Problems	☐ Stomach Problems (ulcers, etc)
☐ Seizures	☐ Blood Disorder/Sickle Cell	☐ Depression
☐ Kidney or Bladder Control Problems	☐ Asthma	☐ Emphysema
☐ Current Smoker	☐ Breathing Problems	

Drink Alcohol: ☐ None ☐ Occasionally ☐ Often

Other:_____

_____

_____

2. Please list type and year of any surgeries you have had:_____

_____

_____

3. Please list any medication or herbal remedies you are currently taking:_____

_____

_____

4. Are you allergic to:

Cortisone/Dexamethasone	☐ Yes	☐ No	Bee Stings	☐ Yes	☐ No
Lidocaine/Novocaine	☐ Yes	☐ No	latex	☐ Yes	☐ No
Pool Chemicals	☐ Yes	☐ No			

Please list any other allergies:_____

5. is there a chance you might be pregnant? ☐ Yes ☐ No

6. Are there any additional issues or concerns that you would like your therapist to be aware of?

_____

_____

_____

Next Doctor's Appointment:_____

Please keep us updated on the date of your next doctor's apt. throughout your treatment program.

_____ _____

Signature **Date**