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
- ☐ 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
- ☐ Other _____

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, hingles)
- ☐ 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