BLACK RIVER MEMORIAL HOSPITAL
Excellence: Always.

PATIENT INFORMATION

HEALTH HISTORY QUESTIONNAIRE

To ensure that you receive a complete and thorough evaluation, please provide us with the important background information on this form. If you do not understand a question the therapist will assist you.

Have you ever been diagnosed as having any of the following conditions?

Cancer - Yes ☐ No ☐ If yes, please describe what kind: _____

High Blood Pressure	Yes ☐	No ☐	Emphysema/Bronchitis	Yes ☐	No ☐
Low Blood Pressure	Yes ☐	No ☐	Pneumonia	Yes ☐	No ☐
Thyroid Problems	Yes ☐	No ☐	Anemia	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐	Osteoporosis	Yes ☐	No ☐
Tuberculosis	Yes ☐	No ☐	Asthma	Yes ☐	No ☐
Stroke / Heart Attack / Pacemaker	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
Depression/ Mental Illness	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Stomach/ Intestinal Problems	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐
Hearing/Vision Impairments	Yes ☐	No ☐	Dislocation	Yes ☐	No ☐
Kidney Disease/Bladder Problems	Yes ☐	No ☐	Sprain	Yes ☐	No ☐
Previous Back/Neck Problems	Yes ☐	No ☐	Circulation Problems	Yes ☐	No ☐
Alcoholism/Chemical Dependency	Yes ☐	No ☐	Fracture	Yes ☐	No ☐
Others:_____			Dizziness/Vertigo	Yes ☐	No ☐

_____

Please list any surgeries that you have had:_____

_____

Are you pregnant or is there any chance you may be pregnant? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐

Are you taking any medications? Please list them: (include over the counter medications and vitamins)

_____

_____

_____

Allergies (i.e. latex):_____

What is your preferred method of learning? How do you best learn?

☐ Pictures ☐ Reading ☐ Listening ☐ Demonstration ☐ Other: _____

Have you recently noted:

Fatigue	Yes ☐	No ☐
Nausea/Vomiting	Yes ☐	No ☐
Weakness	Yes ☐	No ☐
Fever/Chills/Sweats	Yes ☐	No ☐
Weight loss/gain	Yes ☐	No ☐
Numbness or tingling	Yes ☐	No ☐
Night pain	Yes ☐	No ☐

Respiratory Infection Screening:

Have you been experiencing persistent cough or fever? ****If yes (check all that apply)**	Yes ☐	No ☐
Weight loss (unexplained)	Yes ☐	No ☐
Night Sweats	Yes ☐	No ☐
Coughing up blood	Yes ☐	No ☐
Exposed to sick poultry or other animals	Yes ☐	No ☐
Traveled outside of the US in the past two weeks	Yes ☐	No ☐

*** Any checked responses require notification of MD and/or infection control along with appropriate isolation.**

PLEASE COMPLETE OTHER SIDE OF FORM

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PATIENT INFORMATION

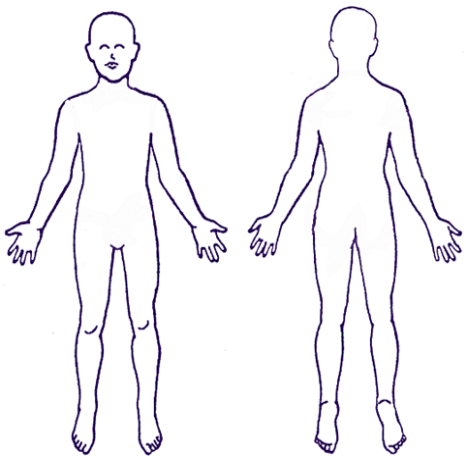
Describe you problem and how it began: (specific dates of onset if possible)_____
_____
_____

What tests have you had for this problem? ☐ XRAY ☐ MRI ☐ CAT scan ☐ Lab test
Other:_____

What other medical professionals have you seen for this problem? _____

Are you currently receiving home care services ☐ YES ☐ NO
If yes, what agency are you using? _____

Please mark area(s) of current symptoms on this diagram



What makes the problem worse?

☐ Nothing ☐ Lying Down ☐ Walking ☐Standing ☐ Sitting ☐ Movement ☐ Inactivity

Other: _____

What makes the problem better?

☐ Nothing ☐ Lying Down ☐ Walking ☐Standing ☐ Sitting ☐ Movement ☐ Inactivity

Other: _____

Occupation: _____ Are you off work because of your problem ☐ Yes ☐ N

Have you ever completed an advance directive or written down any of your thoughts about future medical treatment? Yes ☐ No ☐
Are you interested in receiving more information about advance directives? Yes ☐ No ☐
Information given ☐

Form reviewed with patient? ☐ **Yes** ☐ **No**

_____ _____
Patient Signature **Date**

_____ _____
Therapist's Signature **Date**