Black River MEMORIAL HOSPITAL

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, describe what type, treatment provided and date: _____

High Blood Pressure	Yes ☐ No ☐	Emphysema/COPD	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 ☐
Heart Disease/Stroke /Heart Attack /Pacemaker	Yes ☐ No ☐	Circulation Problems /Blood Clot	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 ☐	Diabetes	Yes ☐ No ☐
Alcoholism/Chemical Dependency	Yes ☐ No ☐	Fracture	Yes ☐ No ☐
Parkinson's Disease/MS	Yes ☐ No ☐	Dizziness/Vertigo	Yes ☐ No ☐

Others: _____

Please list any surgeries that you have had: _____

_____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

☐ Diabetes ☐ Heart Disease ☐ High blood pressure ☐ Stroke ☐ Alcoholism
☐ Inflammatory Disease (Rheumatoid, ankylosing) ☐ Cancer ☐ Depression ☐ Kidney Disease

Are you pregnant or is there any chance you may be pregnant? Yes ☐ No ☐ If yes, how far along? _____months

Do you smoke? Yes ☐ No ☐ **If quit, when?** _____

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

_____

_____

Allergies (i.e. latex, medication): _____

Have you recently experienced:

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

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

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

Any barriers to learning? _____

The above teaching method(s) will be utilized for educational needs throughout the course of therapy.

Black River MEMORIAL HOSPITAL

PATIENT INFORMATION

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

_____

_____

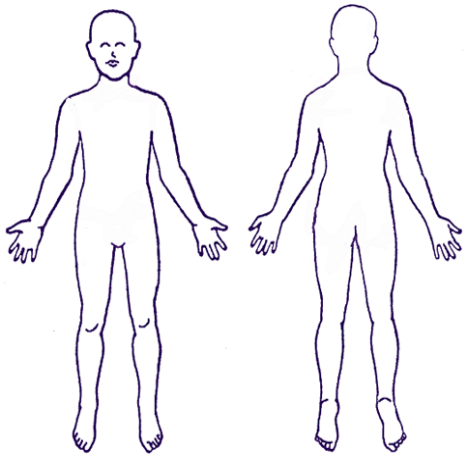
What tests have you had for this problem? ☐ X-ray ☐ MRI ☐ CAT scan ☐ Lab test
Other: _____

Please check any providers you have seen for this or any other condition:
☐ Medical Doctor (MD/DO) ☐ Psychiatrist/Psychologist ☐ Chiropractor, Massage, Acupuncture
☐ Physical Therapist ☐ Dentist ☐ Other: _____

Occupation: _____ Are you off work because of your problem? Yes ☐ No ☐

Hobbies/Goals: _____

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: _____

We realize that relationships may impact your health.

Do you feel anxious or unsafe in any of your relationships? Yes ☐ No ☐
Are there any relationships that make you feel mistreated or powerless? Yes ☐ No ☐
Do you have excessive fear, a loss of interest in yourself, or are you feeling withdrawn? Yes ☐ No ☐

Are you currently receiving homecare services? Yes ☐ No ☐ If yes, what agency are you using? _____
Have you received therapy services in this calendar year? Yes ☐ No ☐ If yes, where? _____

- 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 ☐
- Do you currently have a personal emergency response device? Yes ☐ No ☐
  - If you answered no, are you interested in receiving information about one? Yes ☐ No ☐

Form reviewed with patient? Yes ☐ No ☐

_____ _____
Patient Signature **Date**

_____ _____
Therapist's Signature **Date**