



Patient History Questionnaire

6016 Lovers Lane, Suite 3, Portage, MI 49002

Patient Name: _____

P. (269) 329.0934 F. (269) 329.0965

DOB: _____

MR #: _____

Your therapist will discuss your personal information and goals for therapy with you during the evaluation. Thank you for completing this information.

PERSONAL INFORMATION

I am currently: Employed Employed with restrictions On medical leave Not employed - # Hours/week _____

Interests/hobbies are: _____

Is there anyone who can assist you with doing home exercises or activities, if needed? Yes No

Will you have any problems attending therapy sessions? No Yes If yes, please describe:

General Health

1. Activity level: Low Medium High

2. Are you having trouble sleeping? Yes No

Normal hours of sleep _____ hours.

Current hours of sleep _____ hours

3. Are you experiencing any of the following:

- Apprehension
- Crying episodes
- Less talkative than usual
- Flushing
- Increased perspiration
- Increased negative feelings about injury or future
- Avoiding/uncomfortable with people
- Low energy or frequent fatigue
- Decreased sexual interest
- Weight loss (10 lbs or more)

4. Medical conditions you have or have had. (Check all that apply.)

- Arthritis
- Cancer: In remission Stomach Disorders (*ulcers, etc.*)
- Diabetes
- Heart Disease
- High Blood Pressure
- Lung Disease
- Pacemaker
- Visual problems
- Hearing problems
- Stroke
- Anxiety
- Depression
- Panic Attacks
- Gland Problems (*thyroid*)
- Head injury or trauma
- Asthma
- Other: _____

5. Uncontrolled leakage of urine/loss of bowel control? Yes No

6. Significant dental work? (ie braces, extractions, crowns)

Yes No If yes, please specify: _____

7. Is there any chance you might be pregnant? Yes No

8. Do you smoke? Yes No If yes, packs per day: _____

9. Do you drink alcohol? Yes No If yes, frequency: _____

10. Are you on a special diet? Yes No

Specify _____

11. Are you taking any medications including over the counter, prescription, herbs, supplements, vitamins? Yes No

If yes, please list: _____

12. Do you have any allergies (eg. adhesives, latex, cortizone)?

Yes No If yes, please list with any reactions/treatments:

13. What is the level of your pain?

No Pain Worst Pain Imaginable



PERSONAL GOALS FOR THERAPY

14. What do you **WANT TO** achieve from having therapy? Check all that apply:

- Improve home activities
- Improve leisure/sports activities
- Improve self care activities
- Improve mobility/walking activities
- Improve ability to communicate
- Improve swallowing
- Decrease or eliminate pain/discomfort
- Return to work: Current job Other job
- Other _____

15. Please include any additional information you feel would help us provide your care (ie. what you think would help, any apprehensions about treatment, spiritual or cultural needs).

To the best of my knowledge, the above information is complete and factual.

Patient Signature

Date