

Name _____
DOB _____
MRN _____
PHYS _____

Patient Health History

TO BE COMPLETED BY PATIENT: (please check)

- | | |
|---|--|
| CVA (Stroke): <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Bowel/Bladder <input type="checkbox"/> Yes <input type="checkbox"/> No |
| TBI (Traumatic Brain Injury) <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic Respiratory <input type="checkbox"/> Yes <input type="checkbox"/> No | Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Seizure <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes Mellitus <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Would you like information to help stop
smoking? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Metal Implants/Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Do you have an allergy to latex? Yes No To adhesive tape? Yes No

Other allergies, including medication allergies:

Would you like information regarding advance directives (power of attorney for health care)?
 Yes No

Do you have any current or recent problems with use of alcohol, controlled substances or
prescription drugs? Yes No If you do, please tell us so that we can assist you. .

Do you have any dietary restrictions (such as soft diet, thickened liquids)?

Do you or your key caregivers have any special accommodations needed/preferred learning style
(such as demonstration, reading, discussion, Internet, etc.)?

Do you or your key caregivers have any special cultural/religious needs we should be aware of?

Surgeries? Yes (please list) No:

Orthopedic injuries/conditions? Yes (please list) No:

Have you received previous therapy for your current condition? Yes No

When? _____

Where? _____

Are you currently receiving any other kind of treatment for this condition? Yes No

Please describe:

HOME ENVIRONMENT:

Are you currently living alone or with someone? _____

Can they physically help you, if needed? Yes No N/A

If yes, who? _____ Hrs per day _____

Do you receive help from family or an aide? Yes No N/A

If yes, who? _____ Hrs per day _____

Are you living in your own home or with someone temporarily?

Do you have stairs? Yes No If yes, how many? _____ Do you have a rail? Yes No

Do you have a walk-in shower or tub shower? _____

What bathroom equipment do you have to assist you?

Medications you are currently taking (or please attach list):

Do you (or your family members) need any information we have not provided? If so, please tell your physician and explain here:
