Your therapist will discuss your responses 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  

Employer: ____________________________________  Occupation: ____________________________________

Interests/hobbies/exercise: __________________________________________________________________________

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: ________________________________________________________________

Next scheduled Dr appointment(s):  
Date __________________  Physician __________________

Date __________________  Physician __________________

**KEY QUESTIONS ABOUT YOUR CONDITION**

1. What is your **MAIN** complaint? ____________________________________________________________

2. Darken the areas on the body where you are having problems.

3. Please mark your level of pain with an X along the following lines:

   What is your pain at rest?

   No Pain ____________________________________________________________________________________

<table>
<thead>
<tr>
<th>No Pain</th>
<th>Worst Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Imaginable</td>
</tr>
</tbody>
</table>

   What is your pain with activity?

   No Pain ____________________________________________________________________________________

<table>
<thead>
<tr>
<th>No Pain</th>
<th>Worst Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Imaginable</td>
</tr>
</tbody>
</table>

**GENERAL HEALTH**

4. Are you having trouble sleeping?  
- [ ] Yes  
- [ ] No  
Normal hours of sleep _____ hours  
Current hours of sleep _____ hours

5. Are you experiencing or have any of the following:

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

6. Medical conditions you have or have had. (check all that apply)
   - Arthritis
   - Stroke
   - Cancer: □ In remission
   - Stomach Disorders (ulcers, etc.)
   - Diabetes
   - Anxiety
   - Heart Disease
   - Depression
   - High Blood Pressure
   - Panic Attacks
   - Lung Disease
   - Gland Problems (thyroid)
   - Pacemaker
   - Osteoporosis
   - Visual problems
   - Parkinson’s disease
   - Hearing problems
   - Other
   - Fibromyalgia

7. Have you had any surgical or invasive procedures? □ Yes □ No
   If yes, please list:
   ____________________________________________________________
   ____________________________________________________________

8. Uncontrolled leakage of urine? □ Yes □ No

9. Loss of bowel control? □ Yes □ No

10. Do you smoke? □ Yes □ No
    Packs per day_____

11. Do you drink alcohol? □ Yes □ No
    Drinks per week_____

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

13. Are you on a special diet? □ Yes □ No
    Specify _________________________________________________

14. Are you taking any medications (prescription, over the counter, herbal preparations)? □ Yes □ No
    If yes, please list or □ see attached
    _________________________________________________________
    _________________________________________________________
    _________________________________________________________
    _________________________________________________________
    _________________________________________________________

15. Do you have any allergies (eg. adhesives, latex, cortizone)? □ Yes □ No
    If yes, please list with any reactions/treatments:
    Reaction/Treatment:
    _________________________________________________________
    Reaction/Treatment:
    _________________________________________________________
    Reaction/Treatment:
    _________________________________________________________

16. For patients 12 years and younger, is immunization/vaccination status current? □ Yes □ No

PERSONAL GOALS FOR THERAPY

17. What do you WANT TO achieve from having therapy? Check all that apply:
    □ Improve home activities
    □ Improve mobility/walking activities
    □ Improve leisure/sports activities
    □ Improve ability to communicate
    □ Improve self care activities
    □ Improve swallowing
    □ Decrease or eliminate pain/discomfort
    □ Return to work: □ Current job □ Other job
    □ Other ________________________________

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

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

Patient Signature ___________________________ Date ________________

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Patient History Questionnaire
Rehabilitation Services
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