Outpatient Therapy Medical History Questionnaire

Rev. 07/21

Patient Name: Preferred Name to be addressed: Date of Birth: Preferred Language: Birth Gender: □ Male □ Female □ Choose not to disclose

Gender Identity: □ Male □ Female □ Nonbinary □ Choose not to disclose

1. What is your primary complaint/concern?
2. Injury/Onset Date:
3. Surgery Performed: □ No □ Yes Date of Surgery: Type of Surgery:
4. Related Hospitalization: □ No □ Yes Dates of Hospitalization:
5. Have you fallen in the past year? □ No □ Yes If Yes, how frequent have you fallen?
6. Do you experience pain? □ No □ Yes 0 = None 5 = Moderate 10 = Extreme

Pain at worst 0 1 2 3 4 5 6 7 8 9 10

Pain current 0 1 2 3 4 5 6 7 8 910

Pain at best 0 1 2 3 4 5 6 7 8 9 10

1. Have you recently experienced loss of appetite, anxiety/mood changes, or significant weight gain/loss?

□ No □ Yes If yes, please explain:

1. Are you experiencing any social or emotional difficulties at home/work that we should be aware of?

□ No □ Yes If yes, please explain:

1. Are you experiencing any abuse at home?

□ No □ Yes If yes, please explain:

1. Please check off any of the following medical issues that may apply to you:

□ Alzheimer’s □ Fibromyalgia □ Muscular Dystrophy

□ Cardiovascular Disease □ Fracture or Suspected Fracture □ Obesity

□ Cauda Equina Syndrome □ High Blood Pressure □ Osteoarthritis

□ Cerebral Vascular Accident (Stroke) □ History of Cancer □ Parkinson’s

□ Current Infection □ Huntington’s □ Rheumatoid Arthritis

□ Diabetes Type 1 □ Immunosuppression □ Traumatic Brain Injury

□ Diabetes Type 2 □ Lupus

□ Other: □ Pregnant □ Joint Replacement/Implant □ Seizures □ Pacemaker

1. Do you have any allergies? (i.e. medication, latex) □ No □ Yes
2. Please list current medications, herbals or vitamins or provide med list:

|  |  |  |
| --- | --- | --- |
| Medication | Dose/Frequency | Reason for Taking |
|  |  |  |
|  |  |  |
|  |  |  |

1. What do you want to achieve by coming to therapy? What are your goals?

Patient or Guardian Signature: Date: Time:

Clinician Signature/Print: Date: Time: