

OUTPATIENT HISTORY FORM

Name: _____ Date: _____ DOB: _____ Height: _____ Weight: _____

Occupation: _____ Currently Working: _____ SS#: _____

Emergency Contact: _____ Phone #: _____

Do you have: pacemaker? Yes No Internal stimulator (brain/spinal)? Yes No Are you pregnant? Yes No

Allergies? _____ Allergic to latex? Yes No

Chief Complaint: _____ When did present symptoms start: _____

Cause: _____

What medical help have you sought for current problem? Doctor Chiropractor Physical Therapy Occupational Therapy

Are you currently receiving Home Health Services? Yes No If yes, explain _____

Have you had any x-rays to diagnose current problem? Yes No If yes, when? _____

Have you had other tests performed regarding above problem? _____

Have you had any loss of sensation with current problem? _____

Can you get comfortable at night? _____

Have you had a similar problem before? Yes No If yes, how long ago? _____

Have you ever had physical or occupational therapy for this similar problem? Yes No If yes, what type of treatment did you receive? _____

Do you have pain related to your current problem? Yes No

If YES, please CONTINUE with questionnaire If NO, please STOP - and CONTINUE ON THE OTHER SIDE.

Where is the pain? (mark diagram to the right using the "key")

Has the pain spread? Yes No if yes, where? _____

Describe your pain/symptoms: (check if applicable)

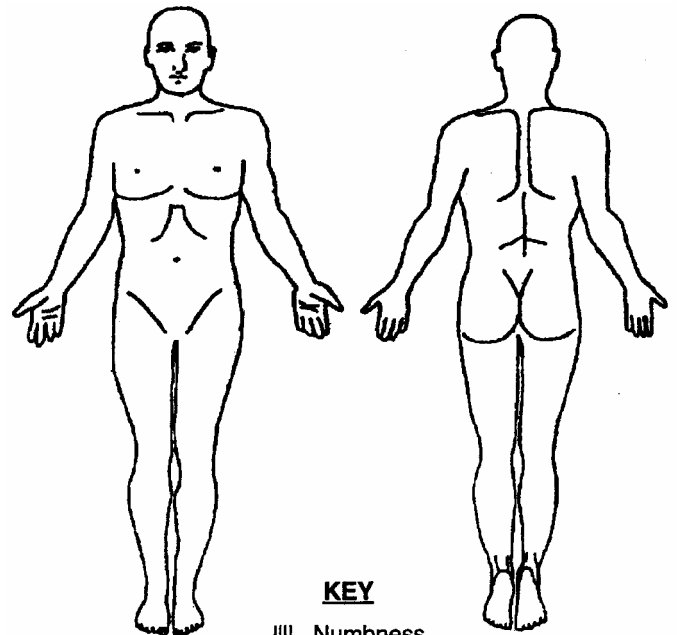
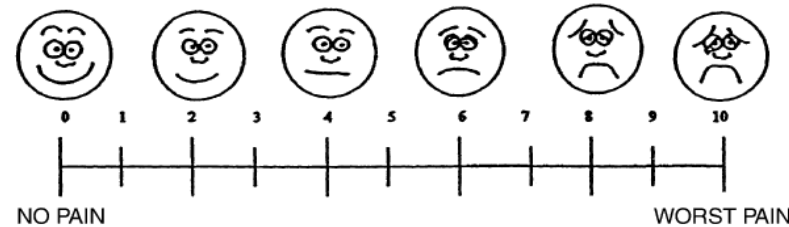
- stays all the time throbbing dull burning shooting
- comes and goes numbness sharp tingling pricking
- pressure aching heavy gnawing

What activities/positions increase your pain? _____

What activities/positions decrease your pain? _____

What activities does pain interfere with or prevent you from doing? _____

Please rate your pain/comfort level using scale below: _____



KEY
 |||| Numbness
 00 Pain
 XX Tingling

What is your goal for pain relief using above scale? _____

(please continue on other side)

Communicable Diseases

Please check all boxes that apply:

Measles:

- Have you ever had the measles? No Yes
- Have received measles vaccine? No Yes
- If no, been exposed within last 2 weeks? No Yes*

For Therapist Use Only
Comments: _____

Chickenpox:

- Have you ever had the chickenpox? No Yes
- Have received chickenpox vaccine? No Yes
- If no, been exposed in the last 2 weeks? No Yes*

Smallpox:

- Have received vaccine within past 4 weeks? No Yes*

If yes to items marked with (), consult Infection Control for notification only. If consult needed .*

Tuberculosis (TB) - Please check all boxes that currently apply to patient and/or guardian:

History

- active TB or history of recent TB (even if on meds)
- NA

Signs and Symptoms

- cough > 2 weeks
- fever and/or chills and/or night sweats
- unintended weight loss > 10 pounds
- bloody sputum
- immune compromised (HIV, cancer, chronic illness)
- none of the above apply

For Therapist Use Only:
Comments: _____

Risk Factors

- jail in the past 2 years
- recent exposure to TB
- foreign born
- homeless or in a shelter
- none of the above apply

Health Insurance Portability Accountability Act

We may be calling to remind you of:

- Appointments/cancellations/rescheduling
- Verify your personal health information
- Any supplies/medical equipment ordered is ready for pick up

If you are not available, we will be leaving a detailed message at (please indicate):

- Work – phone number: _____
- Home – phone number: _____
- Other – phone number: _____
- E-mail address: _____
- NO – please do not leave any messages.**

Emergency Contact Information:

Name: _____ Relationship: _____ Phone Number: _____

Thank you for taking the time to fill out this questionnaire