Center for Rehabilitative and Sports Therapies
Emerson Hospital

PATIENT ID

HEALTH QUESTIONNAIRE

What is the reason your doctor has referred you? _____

Describe your current symptoms_____

Duration of current symptoms_____

Have you received any diagnostic testing for this current condition: **Yes** **No**

What type of testing have you received? X−RAY CT SCAN PET MRI BONE SCAN EMG

Where was the test performed?_____ When?_____

Describe to the best of your knowledge the results of the testing: _____

_____

Are you being hurt or made to feel afraid? Yes NO_____

Please *X* next to any condition listed below that you currently have or may have had

High Blood Pressure	**Diabetes**	**Bowel / Bladder Incontinence**
Heart Attack	**Frequent Urination**	**Painful Urination**
Chest Pain	**Excessive Thirst**	**Stress Incontinence**
Stroke		
Angina	**Impaired Vision**	
Pacemaker	**Impaired Hearing**	**Parkinson's**
	Dizziness / falls	**Polio**
Respiratory Problems		**Post Polio**
Asthma	**History of Cancer**	**Multiple Sclerosis**
Shortness of Breath	**Radiation**	
Lung Disease	**Chemotherapy**	**Depression**
Smoking	**Tumor**	**Mental Illness**
Persistent Cough		
	Difficulty Swallowing	**Fibromyalgia**
Rheumatoid Arthritis	**Heart burn / Reflux**	**Chronic Pain**
Lupus		**Headaches / Inc. Freq.**
Scleroderma	**Arthritis**	
Reynaud's	**Osteoporosis**	**Abnormal Weight gain / loss**
	Osteopenia	**General Fatigue**
Thyroid	**Joint pain / stiffness**	
MRSA	**Pregnant**	
C−Diff	**Menopause**	

*****Have you received any therapy services this calendar year? Yes No**
Circle which services(s) PT OT ST Date: _____

Have you received any therapy services for this current condition: Yes No Date: _____

Patient / Guardian Signature: _____ Date: _____

CLI−000−00003
Reviewed and Approved 06/01/2015

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PROBLEM LIST

Medical Problems

Surgeon_____Proc._____

Date	Problem	Date	Problem

Surgical Procedures/Hospitalizations

Date	Problem	Date	Problem

Medications

Medication	Dose/Frequency		D/C	Date	Medication	Dose/Frequency		D/C	Date

Allergies

Latex: ❑ **Yes** ❑ **No**

Medication/Allergen	Reaction

CLI-000-00003
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