EmersonHospital

CENTER FOR SPORTS REHAB AND SPECIALTY SERVICES

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:**

NOTE: YOUR INSURANCE MAY OR MAY NOT COVER PHYSICAL THERAPY. PLEASE CHECK WITH YOUR INSURANCE PROVIDER PRIOR TO BEGINNING PHYSICAL THERAPY TO VERIFY YOUR COVERAGE.

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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

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