

NRH Regional Rehab

Patient Name: _____

DOB: _____

MR#: _____

Outpatient Health History (Confidential)

Emergency Contact: _____ Relationship: _____ Phone #: _____

Reason for Referral: _____

Person Completing form: _____ Patient Other _____ Date: _____

MEDICAL HISTORY (PLEASE CHECK ALL MEDICAL DIAGNOSIS AND CONDITIONS THAT APPLY)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Current Pregnancy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Irregular or Rapid Heart Beat | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Joint Replacement / Metal Implant | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Work Injury |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Headaches | <input type="checkbox"/> Motor Vehicle Injury | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Communicable Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | |

PAIN: Do you currently have pain or have you had pain in the recent past? YES NO *If Yes, complete Pain Questionnaire*

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS?

- | | | | | | |
|-------------------|--|------------------------|--|-----------------------------------|--|
| Productive cough | Yes <input type="checkbox"/> No <input type="checkbox"/> | Trouble breathing | Yes <input type="checkbox"/> No <input type="checkbox"/> | Constipation | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Fever / Chill | Yes <input type="checkbox"/> No <input type="checkbox"/> | Joint pain | Yes <input type="checkbox"/> No <input type="checkbox"/> | Bloody Stools | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Coughing up blood | Yes <input type="checkbox"/> No <input type="checkbox"/> | Joint stiffness | Yes <input type="checkbox"/> No <input type="checkbox"/> | Difficulty or pain with urination | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Night sweats | Yes <input type="checkbox"/> No <input type="checkbox"/> | Rashes or skin changes | Yes <input type="checkbox"/> No <input type="checkbox"/> | Incontinent bladder | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Nausea / Vomiting | Yes <input type="checkbox"/> No <input type="checkbox"/> | Visual changes | Yes <input type="checkbox"/> No <input type="checkbox"/> | Incontinent bowel | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Chest pain | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hearing changes | Yes <input type="checkbox"/> No <input type="checkbox"/> | Other: _____ | Yes <input type="checkbox"/> No <input type="checkbox"/> |

NUTRITION: Are you concerned about your Nutrition? Yes No
Have you had an unexplained weight gain? Yes No
Have you had an unexplained weight loss? Yes No
Specify loss or gain: _____ lbs

FALLS: Are you concerned about falling? Yes No
Have you fallen in the last year? Yes No If yes, Date : _____
Have you fallen more than 2 times? Yes No
Has any fall resulted in injury? Yes No Specify: _____

IMMUNIZATION: (For Pediatric Patients Only) Check (✓) if you have been immunized for the following:

- DPT (Diphtheria, Pertussis, Tetanus) Yes No
Chickenpox (Varicella) Yes No
MMR (Measles, Mumps, Rubella) Yes No

SURGERIES / HOSPITAL PROCEDURES

ALLERGIES / DRUG INTERACTIONS Many rehab clinic products contain Latex. *Do you have any allergy to Latex?* Yes No

CURRENT MEDICATIONS (INCLUDE OVER-THE-COUNTER MEDICATIONS AND HERBAL PREPARATIONS)

Medication Name	Dose	Frequency	Reason

The above information has been reviewed and discussed with the patient. This information will be incorporated into the treatment goals and plan of care established in collaboration with patient.

Clinician Signature: _____	Date: _____	Date: _____
Clinician Signature: _____	Date: _____	Date: _____
Clinician Signature: _____	Date: _____	Date: _____
Clinician Signature: _____	Date: _____	Date: _____
Clinician Signature: _____	Date: _____	Date: _____

NRH Regional Rehab

Initial Evaluation Pain Questionnaire / Assessment

Patient Name: _____

DOB: _____

MR #: _____

① Please rate your pain by circling the number that describes your pain at **its worst in the last three (3) days:**

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst pain

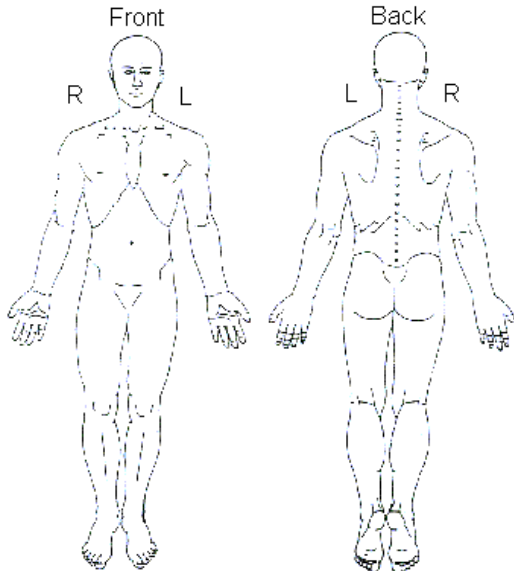
② Please rate your pain by circling the number that describes your pain at **its least in the last three (3) days:**

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst pain

③ Please rate your pain by circling the number that tells how much **pain you have right now:**

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst pain

④ On the diagram below, shade in the areas on the body where you feel pain. Put an X on the area that hurts most:



⑤ Place a check mark (✓) in the Yes or No box if the word describes your pain. If the symptom is present, indicate with a check mark (✓) if the pain is constant or occasional.

Aching	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Occasional
Throbbing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Occasional
Shooting	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Occasional
Stabbing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Occasional
Gnawing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Occasional
Sharp	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Occasional
Tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Occasional
Burning	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Occasional
Exhausting	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Occasional
Tiring	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Occasional
Penetrating	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Occasional
Nagging	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Occasional
Numbing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Occasional
Miserable	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Occasional
Unbearable	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Occasional

Other word(s) to describe your pain: _____

⑥ During the past three (3) days, indicate what your pain has interfered with: Check (✓) all that apply

Self care ability Walking ability Work Sleep General Activity Mood Concentration _____
Other: _____

⑦ What kinds of things make your pain worse? (for example: bending, walking, turning, in the morning, after activity)

⑧ What kinds of things make your pain feel better? (for example: rest, heat, medicine)

Pain Questionnaire Completed by: _____

The above information has been reviewed and discussed with the patient. This information will be incorporated into treatment goals and plan of care established in collaboration with patient.

Clinician Signature: _____ Date: _____
 Clinician Signature: _____ Date: _____
 Clinician Signature: _____ Date: _____

