

HLBI  HLNC  HLDT  SBH  SLBH  NBH

**OUTPATIENT PHYSICAL REHABILITATION  
PATIENT MEDICAL HISTORY AND FUNCTIONAL SURVEY**

PATIENT NAME: \_\_\_\_\_  
AGE: \_\_\_\_\_ DOB: \_\_\_\_\_ SEX: \_\_\_\_\_

**PATIENT LABEL**

MEDICAL RECORD # \_\_\_\_\_  
ACCOUNT # \_\_\_\_\_

1. For what primary problem(s) did your doctor send you to therapy? \_\_\_\_\_

Are any of the following part of your medical history? (Mark all that apply)

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> Heart Attacks / Bypass / Pacemaker                                | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Asthma       |
| <input type="checkbox"/> Neurological Problems   | <input type="checkbox"/> Stroke: Right / Left | <input type="checkbox"/> Neuropathy   |
| <input type="checkbox"/> Respiratory / Pulmonary Disease                                   | <input type="checkbox"/> Headaches / Migraine | <input type="checkbox"/> Arthritis    |
| <input type="checkbox"/> High or Low Blood Pressure  | <input type="checkbox"/> Incontinence         | <input type="checkbox"/> Nausea       |
| <input type="checkbox"/> Diabetes: Diet / Insulin  | <input type="checkbox"/> Balance Problems     | <input type="checkbox"/> Scoliosis    |
| <input type="checkbox"/> Visual Impairment   | <input type="checkbox"/> Hearing Impairment   | <input type="checkbox"/> Dizziness    |
| <input type="checkbox"/> Brain Trauma  | <input type="checkbox"/> Open Sores / Wounds  | <input type="checkbox"/> Falls        |
| <input type="checkbox"/> Foot Problems   | <input type="checkbox"/> Generalized Weakness | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Use / Abuse: Tobacco / Alcohol / Recreational Drugs               |   |                                       |
| <input type="checkbox"/> Fractured: Spine / Arm / Wrist / Hip / Leg / Ankle / Other: _____ |   |                                       |

3. List any prior surgeries/procedures: \_\_\_\_\_

4. List any daily activities you are having difficulty performing(e.g. bending, driving, dressing, getting into the car, dishwashing,etc) \_\_\_\_\_

5. What are your goals for your treatment? \_\_\_\_\_

6. Do you have any of the following symptoms? (mark all that apply)

- Pain     Weakness     Tingling     Stiffness     Swelling     Numbness  
 Spasms     Other (Please list): \_\_\_\_\_

7. Since the onset of your present complaints, have the symptoms:

- Decreased     No Change     Varies     Increased

8. Please rate your pain (for example, 0-10 or mild, moderate, or severe) \_\_\_\_\_

9. Location(s) of pain: \_\_\_\_\_

10. How long have you had this pain? \_\_\_\_\_

11. Describe your pain (for example: constant, intermittent, aching, dull, sharp): \_\_\_\_\_

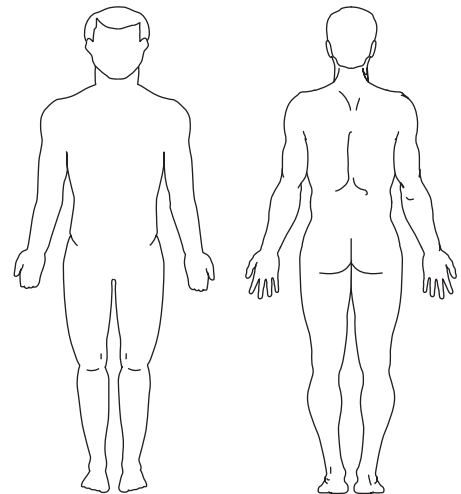
11. Acceptable level of pain: \_\_\_\_\_

12. What relieves your pain? \_\_\_\_\_

13. What makes it worse? \_\_\_\_\_

14. Please mark your affected areas on the body diagram.

15. **Therapy staff:** If patient is unable to self-report pain, enter pain intensity here based on Behavioral Scale on BHS Universal Pain Assessment Tool: \_\_\_\_\_



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Please rate your abilities using the following scale:

1 = can do without difficulty    2 = can do with some difficulty    3 = can do with great difficulty    4 = can't do at all

**Comments: Therapist use only**

Lying down	1	2	3	4	
Sitting	1	2	3	4	
Standing	1	2	3	4	_____
Walking	1	2	3	4	
Jogging/Running	1	2	3	4	_____
Going up stairs	1	2	3	4	
Going down stairs	1	2	3	4	_____
Lifting/Carrying	1	2	3	4	
Driving a car	1	2	3	4	_____
Overhead reaching	1	2	3	4	
Housework	1	2	3	4	_____
Yardwork	1	2	3	4	
Dressing	1	2	3	4	_____

Are you exercising at home?     Yes     No    If yes, what type? \_\_\_\_\_  
 Are you using heat or cold?     Yes     No    If yes, what type? \_\_\_\_\_  
 Are you wearing a sling or a brace?  Yes     No    If yes, what type? \_\_\_\_\_  
 Do you smoke?     Yes     No    If yes, how much? \_\_\_\_\_

What type of non-work activities are you involved in? \_\_\_\_\_

When are you scheduled to see your doctor again? \_\_\_\_\_

Therapist's Comments: \_\_\_\_\_

**To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services within Baptist Health System.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Emp#: \_\_\_\_\_ Date: \_\_\_\_\_