Patricia Neal Rehabilitation Center
Restoring Abilities. Rebuilding Lives.

Patient Health History

Patient Name: _____ Date: _____
Print Signature

Name of person completing form: _____
Relationship to patient

Living Environment – Do you live in a ☐ House ☐ Apartment ☐Mobile Home?
Check all of the following that apply:
☐Stairs, no railing ☐Stairs, railing ☐ Ramps ☐Uneven terrain ☐Elevator ☐ Other: _____
Assistive devices:
☐Wheelchair ☐Walker ☐Cane ☐Tub Bench
☐ Hand Held Shower Head ☐ Raised/Bedside Commode ☐Hospital Bed
☐ Scooter ☐ Brace ☐ Prosthesis ☐Other: _____
Are you currently driving? ☐ **Yes** ☐ **No**
Who took care of Finances in household prior?_____Now?_____
With whom do you live?☐ Alone ☐ Spouse ☐ Children ☐Parents ☐Other _____
Do you have any trouble getting in or out of any room in your home? _____
Number of falls you have had in the past 6 months? _____
Are you ☐ Right handed? ☐Left handed?

Employment / Work (Job/School/Play) / Home Activity

Occupation: _____ ☐ Working full-time ☐ Working part-time
☐Homemaker ☐ Student ☐Retired ☐Unemployed
Highest level of Education: ☐Grade school ☐ High school ☐ College ☐ Technical school
If Student, current GPA _____ Grade level _____Enrolled in classes? ☐ **Yes** ☐ **No**
Currently on disability? ☐ **Yes** ☐ **No** Applying for disability? ☐ **Yes** ☐ **No**
If employed, where?_____How long employed? _____Position waiting? _____
Job responsibilities: _____
Work history: _____

Health Habits

Mental Health: How would you rate your quality of life? ☐**Good** ☐ **Fair** ☐**Poor**
Do you feel that your situation is hopeless? ☐**Yes** ☐ **No**
Do you feel happy most of the time? ☐**Yes** ☐ **No**
Would you like more information on managing your mood or with coping strategies? ☐**Yes** ☐ **No**
Smoking: Currently? ☐**Yes** ☐ **No** Past? ☐ **Yes** ☐ **No** Amount _____
Alcohol: Currently? ☐**Yes** ☐ **No** Past? ☐ **Yes** ☐ **No** Amount _____
Recreational Drug Use: Currently? ☐**Yes** ☐ **No** Past? ☐ **Yes** ☐ **No** Amount _____
Do you exercise beyond normal, daily activities and chores? ☐ **Yes** ☐ **No** ☐Home Exercise Program
Describe a typical day before your injury: _____
Describe a typical day now: _____

Within the <u>past year</u>, have you had any of the following symptoms? (Check all that apply):

☐Chest pain
☐Headaches
☐Coordination problems
☐Difficulty walking
☐Difficulty sleeping
☐Difficulty swallowing
☐Hearing problems
☐Skin changes
☐Bowel problems
☐Shortness of breath
☐Weakness in arms or legs
☐Joint pain or swelling
☐Loss of appetite
☐Weight gain
☐Vision problems/changes
☐Urinary problems
☐Dizziness or blackouts
☐Loss of balance
☐Pain at night
☐Fever / chills / sweats
☐Weight loss
☐Other: _____

Medical / Surgical History Please check if you have ever had (check all that apply):

☐Arthritis ☐Broken bones / fractures ☐Osteoporosis
☐Heart attack ☐Circulation / vascular problems ☐Heart problems
☐Stroke ☐High blood pressure ☐Lung problems
☐Head injury ☐ Diabetes / high blood sugar ☐Hypoglycemia / low blood sugar
☐Parkinson's disease ☐Multiple Sclerosis ☐Allergies
☐Developmental or growth problems ☐ Seizures or epilepsy ☐Latex allergy
☐Ulcers / stomach problems ☐Thyroid problems ☐Kidney problems
☐Skin disease ☐ Depression ☐Cancer
☐Infectious disease (e.g. tuberculosis, hepatitis) ☐Other: _____
☐COPD ☐Sleep Apnea ☐Nausea/Vomiting ☐Previous Therapy ☐Pacemaker
☐ Chemotherapy ☐ Radiation

Please list any surgeries and include approximate dates (month/year):

_____ _____/_____ _____/_____
_____ _____/_____ _____/_____

Other Clinical Tests (Within the past 6 months):

☐Angiogram (heart catheter) ☐Bone scan ☐CT scan
☐EKG (electrocardiogram) ☐Mammogram ☐MRI
☐NCV (nerve conduction velocity) ☐X-rays ☐Stress test (e.g. tread mill, bicycle)
☐MBSS (Swallow study) ☐pulmonary function test ☐Other: _____

FOR MEN ONLY: Have you been diagnosed with prostate disease? ☐**Yes** ☐**No**
FOR WOMEN ONLY: Are you pregnant or think you might be pregnant? ☐**Yes** ☐**No**
Have you been diagnosed with other OB/GYN difficulties? ☐**Yes** ☐**No**

Current Conditions / Chief Complaints

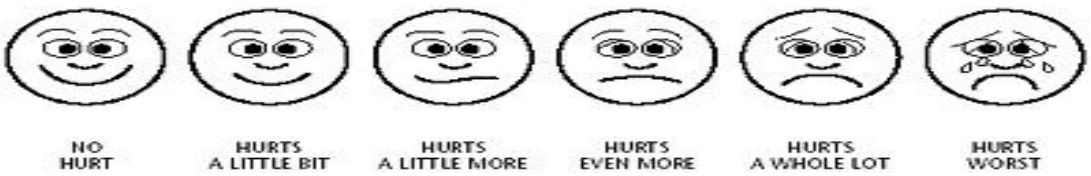
When did the problem(s) begin? (Month/year) _____/_____
What happened?_____
Have you ever had this problem before? ☐**Yes** ☐**No**
***If yes*:** How long did the problem(s) last? _____
What did you do for the problem(s)? _____
Did the problem get better? ☐**Yes** ☐**No**
How are you taking care of the problem(s) now? _____
What are your goals while in Rehab?_____
_____
Are you seeing any healthcare providers for your current problem(s)? (Please list) _____
_____

Allergies?

Please list all allergies:_____

Pain: Please indicate your level of pain at this time by marking on the visual scale:

0 1 2 3 4 5 6 7 8 9 10
None Mild Moderate Severe Very Severe



Reviewed by: _____