The Virginian Rehabilitation Department

PERSONAL HEALTH HISTORY FORM

Client's Name: _____ Date: _____

DOB:_____ Therapist: _____

Diagnosis: _____Date of Onset: _____

Physician: _____ Date of Surgery (if any): _____

Symptoms within the past year	No	Yes	*If yes, please explain
Angina or chest pain			
Shortness of breath			
Migraines or headaches			
Depression or anxiety			
Dizziness or blackouts			
Coordination problems			
Weakness in arms or legs			
Loss of balance			
Difficulty walking			
Joint pain or swelling			
Difficulty sleeping			
Loss of appetite			
Difficulty swallowing			
Changes to voice or speech			
Changes in memory			
Bowel problems			
Weight loss/gain			
Urinary problems			
Fever/chills/sweats			
Allergies (*If yes, please list)			

Name:_____ Date: _____/_____/_____

Past Medical History	No	Yes	*If yes, please explain
Cancer			
Heart Disease			
Hypertension or high blood pressure			
Hypotension or low blood pressure			
Stroke			
Deep vein thrombosis or blood clots			
Blood disorders			
Neuropathy			
Ulcers/stomach problems			
Pneumonia			
Emphysema			
Chronic bronchitis			
Tuberculosis			
Asthma, hay fever			
Rheumatic/scarlet fever			
Diabetes			
Hypoglycemia or low blood sugar			
Kidney disease or kidney stones			
Liver disease or Cirrhosis			
Hepatitis or jaundice			
Osteoarthritis			
Rheumatoid arthritis/Gout			
Osteoporosis/Osteopenia			
Fibromyalgia/myofascial pain syndrome			
Dementia or memory problems			
Parkinson's Disease			
Progressive Supranuclear Palsy			
Huntington's Disease			
Multiple System Atrophy			
Multiple Sclerosis			
Guillain-Barre Syndrome			
Muscular Dystrophy			
Epilepsy			
Polio			
Head injury			
Hydrocephalus			
Thyroid problems			

Name:_____ Date: _____/_____/_____

General Health	NO	YES	*If yes, please explain
Are you taking any prescription or over the counter medications? *Please attach list with dosage			
Have you had an illness within the last 3 weeks? (E.g., colds, influenza, bladder of kidney infection)?			
Have you noticed any lumps or thickening of skin or muscle anywhere on your body?			
Do you have any sores that have not healed or any changes in size, shape, color of a wart or mole?			
Have you had any unexplained weight gain or loss in the last month?			
Do you smoke or chew Tobacco? * Please indicate how many packs a day? *For how long?			
Do you drink alcohol regularly? *If yes, how much in the course of a week?			
Do you drink caffeine regularly? *If yes, how much daily (including soft drinks, coffee, tea, chocolate)?			
Are you on any special diet prescribed by a physician? *If yes, please explain the diet/ restrictions			
Do you have a pacemaker, transplanted organ, joint replacement, or metal implants? *Please indicate where?			
Have you experienced any changes in bowel or bladder function?			
Do you wear hearing aides?			
Do you wear dentures?			
Do you have any visual impairments?			
Do you feel safe in your home?			
During the past month, have you been bothered by feeling down, depressed, hopeless? *If yes, how often?			

Name:_____ Date: _____/_____/_____

Medical Testing	NO	YES	*If yes, please explain
Have you had x-rays, sonograms, computed tomography (CT) scans, or magnetic resonance imaging (MRI) done recently? *If yes, when, where, results?			
Have you had any laboratory work done recently (urinalysis or blood tests)? *If yes, when, where, results?			
Have you had any broken bones or fractures? *If yes, when, where?			
Please list any medical operations and dates: 1.) 2.) 3.) 4.) 5.)			
Have you noticed increased confusion or difficulty concentrating?			
Are you currently experiencing any pain? * If yes, how often, describe the pain			

Social History/Environment:

1.) Cultural/Religious: Any customs or religious beliefs or wishes that might affect care?

_____

2.) With whom do you live:

___ alone
___ spouse
___child
___ Other: _____
___ other relative
___ caregiver

3.) Employment/ Work:

___ full-time
___ homemaker
___ unemployed
___ part-time
___ retired
___ student

___ other: _____

Living environment: (check all that apply)

1.) Where do you live:

___ private home
___ apartment
___ group home
___ other: _____
___ long-term care facility
___ assisted living

2.) Does your home have:

_____ Stairs, no railing
_____ Stairs, railing
_____ Ramps
_____ Elevator
_____ Uneven terrain
_____ Assistive devices (i.e. grab bars, shower chair, bed rails): _____
_____ Any obstacles:_____

3.) Do you use:

_____ Cane (single-point or quad)
_____ Walker or rollator
_____ Manual Wheelchair
_____Motorized wheelchair
_____ Glasses, hearing aids
_____ No Assistive Devices
____ Other: _____

Functional status/ Activity Level: (Check if you have difficulty with)

_____ Locomotion/ movement:
_____ Bed mobility
_____ Transfers (i.e. moving from bed to chair, bed to commode)
_____ Gait (walking)
_____ On level surface _____ On ramps
_____ On stairs _____ On uneven terrain
_____ Self-care (i.e. bathing, dressing, eating, toileting)
_____ Home management (i.e. household chores, shopping, driving/ transportation, care of dependents)
_____ Community and work activities/integration
_____ Work/ School _____ Recreation or play activity

_____ No difficulties

Name:_____ Date: _____/_____/_____

For the therapist:	
Vital Signs:	
Resting pulse rate:	
Blood pressure reading #1: -Position:	
Blood pressure reading #2: -Position:	
SPO_2% (at rest):	
SPO_2% (with activity):	
Temperature (if applicable):	

This form was reviewed and discussed on _____(date).

_____ _____

Client Signature Therapist Signature