

Name	Today's Date
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What is the reason your doctor sent you for treatment and what do you want us to help you be able to do?

How long have you had this problem? (please give a date or length of time)

Medical History

*Are you receiving any home nursing or home therapy? Yes No

(Is any healthcare provider coming to your home to check your blood pressure or give you medications?)

*If Yes, who is the home health agency? _____

Past Hospitalizations/Surgeries: _____

Please list medications that you are currently taking.

Medication	Prescribing Physician	Phone # of Prescribing Physician

Do you have any known medication allergies? Yes No If Yes, please list

Please place an "X" in front of all the answers that apply to you.

Which of the following medical conditions do you *currently* have and give dates to when this/these occurred?

<input type="checkbox"/> Asthma	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Degenerative Joint Disease
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Stroke	<input type="checkbox"/> Carpal Tunnel Syndrome
<input type="checkbox"/> Lupus	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Back Injury	<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Depression, Anxiety and/or any other mental illness
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Cancer
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Bone Fracture	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> COPD	<input type="checkbox"/> AIDS	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Other:

Please indicate with an "X" whether you do them alone or with help.

Alone	With Help		Alone	With Help	
<input type="checkbox"/>	<input type="checkbox"/>	Walking	<input type="checkbox"/>	<input type="checkbox"/>	Getting in and out of bed
<input type="checkbox"/>	<input type="checkbox"/>	Eating/Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Getting in and out of chairs
<input type="checkbox"/>	<input type="checkbox"/>	Household activities	<input type="checkbox"/>	<input type="checkbox"/>	Getting in and out of the bath
<input type="checkbox"/>	<input type="checkbox"/>	Grooming/Bathing/Toileting	<input type="checkbox"/>	<input type="checkbox"/>	Speaking
<input type="checkbox"/>	<input type="checkbox"/>	Meal preparation	<input type="checkbox"/>	<input type="checkbox"/>	Hearing
<input type="checkbox"/>	<input type="checkbox"/>	Dressing	<input type="checkbox"/>	<input type="checkbox"/>	Remembering
<input type="checkbox"/>	<input type="checkbox"/>	Personal Finances	<input type="checkbox"/>	<input type="checkbox"/>	Problem Solving
<input type="checkbox"/>	<input type="checkbox"/>	Transportation			

Has your current illness or injury caused any of the following?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Financial Stress	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Family Problems	<input type="checkbox"/>	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	<input type="checkbox"/>	Anger	<input type="checkbox"/>	<input type="checkbox"/>	Fear
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Sadness	<input type="checkbox"/>	<input type="checkbox"/>	Frustration
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal Thoughts

Do you smoke? Yes No If yes, packs/day: _____

Do you currently have an Advanced Directive or Out of Hospital Do-Not-Resuscitate order?

Yes No

Are you seeing a Social Worker, Counselor, Psychologist, and/or Psychiatrist for your current troubles?

Yes No

Would like to meet about a referral to a Counselor, Neuropsychologist or Social Worker?

Yes No

Printed name of person that completed this form, if not the patient

Relationship to the patient:

Signature of person that completed this form:

Date: