WASHINGTON HEALTH SYSTEM

OUTPATIENT REHABILITATION SERVICES

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REHABILITATION SERVICES OUTPATIENT QUESTIONNAIRE

NAME _____ DATE _____

Medical History

- The following is a list of common health problems. In the first column please indicate those problems that you have had in the past. In the second column indicate those problems for which you are currently receiving treatment. ***Check only those that apply to your situation.***

	Problems you have had	**Problems for which you currently receive treatment**	**Comments (For official use only)**
Heart disease	❒	❒	
High blood pressure	❒	❒	
Lung disease	❒	❒	
Diabetes	❒	❒	
Ulcer or stomach problems	❒	❒	
Kidney or liver disease	❒	❒	
Anemia or other blood diseases	❒	❒	
Cancer	❒	❒	
Anxiety, depression or panic attacks	❒	❒	
Seizures	❒	❒	
Fainting, dizziness or vertigo	❒	❒	
Stroke, MS, Parkinsons, or other nerve disease/disorder	❒	❒	
Arthritis	❒	❒	
Muscle, bone or joint injury	❒	❒	
Hearing loss	❒	❒	
Headaches or migraines	❒	❒	
Vision loss or blurred vision	❒	❒	
Allergies	❒	❒	
Skin disease	❒	❒	

Patient Label

Other medical problems please specify:

1. _____
2. _____
3. _____

- Do any of your immediate family members (parent, sibling) have a history of heart disease prior to the age of 55?
  - ❒ Yes ❒ No
- Have you had a physical examination in the last year?
  - ❒ Yes ❒ No
- Have you had any surgery?
  - ❒ Yes ❒ No
  - If yes: Surgery date_____ Surgery Type_____
- Are you currently taking any medications (over the counter and/or prescribed)?
  - ❒ Yes ❒ No
  - If yes, please list the medications that you are taking:

    _____

    _____
- What is your current employment status? (Check the one category that best describes your current work status)
  - ❒ Work regular duty full time
  - ❒ Work regular duty part time
  - ❒ Work light duty or modified position full time
  - ❒ Work light duty or modified position part time
  - ❒ Temporarily unable to work due to health status
  - ❒ Permanently unable to work or retired due to health status
  - ❒ Retired (not due to health status)
  - ❒ Unemployed
  - ❒ Homemaker (not working outside the home)
  - ❒ Student (not currently working)
- Do you feel safe in your home environment from physical, mental, verbal, or financial abuse/neglect?
  - ❒ Yes
  - ❒ No

Patient Label

How did your injury or condition develop?

- ❒ Activities of daily living
- ❒ Motor vehicle accident
- ❒ Sports (specify)_____
- ❒ Work
- ❒ Following surgery
- ❒ Following an illness
- ❒ Other (specify)_____

- What date did you first experience the discomfort or symptoms you are having now?

  _____

- How did your symptoms or discomfort start or happen?

  _____

- Have you ever had similar complaints/problems in the past?

  ❒ Yes ❒ No

  If yes, have you ever been treated?

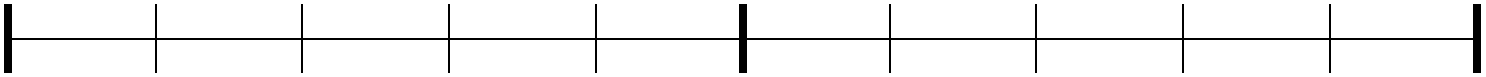
  ❒ Yes ❒ No

  Previous treatment:_____

  Treatment date:_____

- Pain scale: Please rate pain on scale, "0" being no pain and "10" being severe emergency room pain. Circle appropriate number.

0 – 10 NUMERIC PAIN INTENSITY SCALE



0	1	2	3	4	5	6	7	8	9	10
No Pain		**Minimal Pain**			**Moderate Pain**		**Severe Pain**		**Extreme, Emergent Pain**	

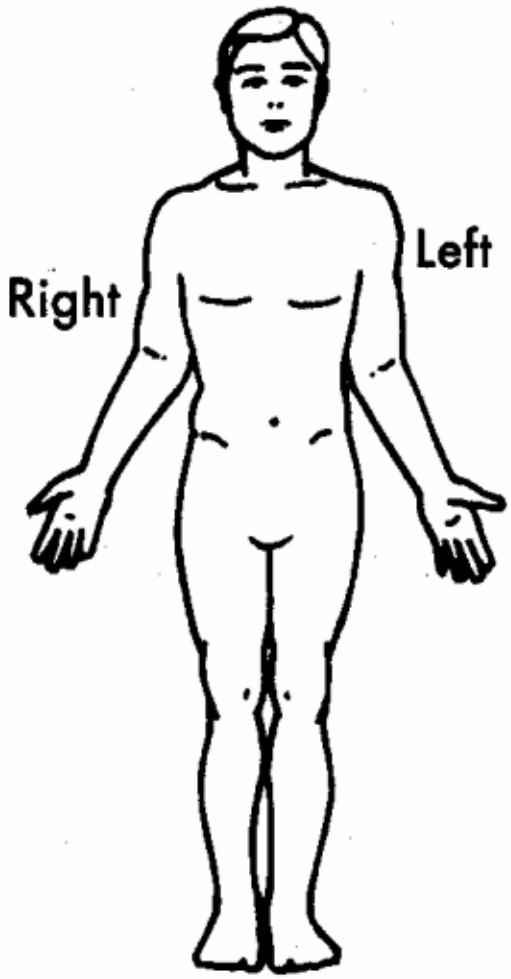
Patient Label

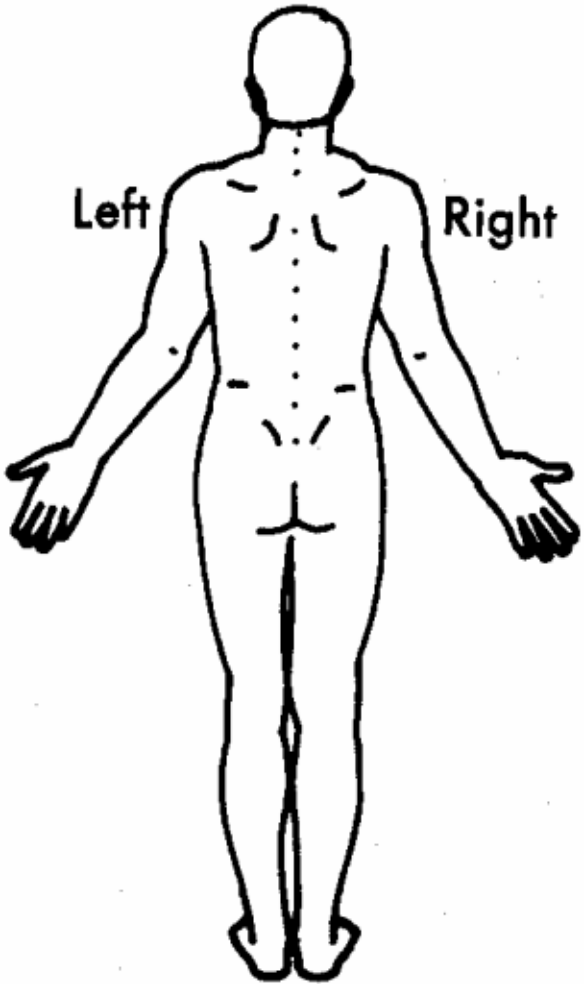
PAIN DRAWING

WHERE IS YOUR PAIN NOW?

Use appropriate symbols shown below to mark the areas on your body where you feel these described sensations. Include ALL areas affected by your pain, and mark the type and area of pain if it radiates or spreads to other areas.

Burning ⊠	Numbness O	Pins & Needles =	Stabbing /	Ache ⊠





Patient Label

Signature