Medical History Questionnaire

Today's Date:____________
Date of Birth: ______________

Patient Name:____
Gender: ☐ Female ☐ Male Hand Dominance: ☐ Right ☐ Left

EDUCATION:
Highest Grade Completed: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12
☐ Some College/Technical School ☐ College Graduate ☐ Graduate School

SOCIAL HISTORY:
Cultural/Religious: Do you have any Customs or Religious beliefs or wishes that might affect care?____

Employment/School/ Leisure: ☐ Working F/T ☐ Working P/T ☐ Homemaker
☐ Student ☐ Retired ☐ Unemployed
Occupation:____

LIVING ENVIRONMENT:
Does your home have: ☐ Stairs Outdoors. ☐ Stairs Indoors ☐ Ramp. ☐ Elevator
☐ Uneven Terrain ☐ Other:____
Do you use: ☐ Cane ☐ Walker ☐ Manuel Wheelchair. ☐ Motorized Wheelchair
☐ Other____

Do you live in a: ☐ Private Home ☐ Private Apartment ☐ Rented Room ☐ Hospice
☐ Assisted Living/Group Home ☐ Long-term Care Facility ☐ Homeless
☐ Other:____

Does anyone live with you: ☐ Yes ☐ No
Name:__________________________________Relationship:______________________

MEDICAL HISTORY:
Please check if you have ever had:

☐ Arthritis
☐ Circulation Problems
☐ Stroke
☐ Multiple Sclerosis
☐ Allergies
☐ Kidney Problems
☐ Depression
☐ Broken Bones
☐ Heart Problems
☐ Diabetes
☐ Muscular Dystrophy
☐ Thyroid Problems
☐ Repeated Infections
☐ Osteoporosis
☐ High Blood Pressure
☐ Low Blood Sugar
☐ Parkinson Disease
☐ Cancer
☐ Ulcers/Stomach Problems
☐ Blood Disorders
☐ Lung Problems
☐ Head Injury
☐ Seizures/Epilepsy
☐ Infectious Disease
☐ Skin Disease

☐ Other:____

Have you ever had surgery: ☐ Yes ☐ No
Surgery____Date________________
Surgery____Date________________
Surgery____Date________________

Have you received physical therapy in the past 12 months? ☐ Yes ☐ No

Have you received Home Health Services in the last 6 months? ☐ Yes ☐ No

Do you still have Home Health Staff at your home? ☐ Yes ☐ No

Do you receive home delivery of any of the following: Oxygen, Diabetic Supplies, CPCP supplies or any other services?____

GENERAL HEALTH:
Please rate your health: ☐ Excellent. ☐ Very Good ☐ Fair ☐ Poor
Do you currently smoke tobacco? ☐ Yes ☐ No If yes, how many packs per day:_______________
Did you smoke in the past? ☐ Yes ☐ No If yes, year you quit:____________________________
If you drink alcohol (beer, wine, etc), how may days per week do you drink on average?___________
Do you exercise beyond normal daily activities and chores? ☐ Yes ☐ No If yes, describe exercise:

For Men ONLY: Have you been diagnosed with Prostate Disease? ☐ Yes ☐ No

For Women ONLY: Have you been diagnosed with:
Pelvic Inflammatory Disease? ☐ Yes ☐ No Endometriosis? ☐ Yes ☐ No
Trouble with your period: ☐ Yes ☐ No Complications with Pregnancy/Delivery? ☐ Yes ☐ No
Pregnant or think you might be? ☐ Yes ☐ No
Other Gynecological or obstetrical difficulties? ☐ Yes ☐ No If yes, describe_____________________
____

CURRENT CONDITIONS(S)/CHIEF COMPLAINT(S)
Describe the problem(s) for which you seek physical therapy.______________________________
____

When did current problem(s) begin? Date_________
Have you had this problem before? ☐ Yes ☐ No
How are you taking care of the problem now?____
Are you seeing anyone else for this problem? ☐ Yes ☐ No If yes, name:______________________

FUNCTIONAL STATUS/ACTIVITY LEVEL (Check all that apply):
☐ Difficulty with locomotion/movement ☐ Bed Mobility ☐ Transfers (such as bed to chair)
☐ Walking ☐ Difficulty with self-care (such as bathing, dressing, eating, toileting)
☐ Difficulty with home management (such as shopping, driving, care of dependents, household chores)
☐ Difficulty with work, school, recreation, or leisure activities

MEDICATIONS:
Do you take any prescription medications? ☐ Yes ☐ No If yes, please list:______________________
____

Do you take any non-prescription medications? ☐ Yes ☐ No If yes, check all that apply:

☐ Decongestants	☐ Tylenol	☐ Vitamins
☐ Antihistamines	☐ Advil/Aleve	☐ Herbal Supplements
☐ Ibuprofen/Naproxen	☐ Aspirin	

☐ Other:____

Allergy to medications:____

Wilmington Health Physical Therapy

PATIENT AUTHORIZATION

PATIENT NAME:________________________________

All information provided herein is true and correct.

I hereby consent to treatment.

I will give permission to Wilmington Health Physical Therapy and its subsidiaries and affiliates to release information, verbal and written, contained in my medical record, and other information, to my insurance company rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates my treatment.

I authorize Wilmington Health Physical Therapy and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

Information, without patient identifiers may be used for quality assurance purposes.
I authorize payment directly to Wilmington Health Physical Therapy its subsidiaries and/or affiliates for services.

This is a direct assignment of my rights and benefits under this policy.

A photocopy of this assignment shall be considered as effective and valid as the original.
I agree to pay Wilmington Health Physical Therapy, its subsidiaries and/or affiliates for the services provided to me or the party named above. If any law, such as workers compensation, or insurance contract prohibits payment or these services, I will cooperate and assist in the provision of information, authorizations, releases or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment of services.

I further understand that is agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Wilmington Health Physical Therapy and/or its subsidiaries of affiliates.

We strive to provide the highest quality care for each of our patients. In an effort to do this, we try to initiate therapy as quickly as possible and schedule follow-up appointments appropriately. As the therapists work with individuals, a plan of care is established which gives frequency and duration of physical therapy treatments. Scheduling is very important as to how effective we can be in providing quality care and achieving the goals set. Please make appointments that will work comfortably into your schedule. We appreciate 24 hours notice if you need to cancel or change an appointment.

Patient or Guardian Signature____

Date____________