



1600 North Second Street  
Clinton MO 64735  
660-885-5511

### Rehabilitation Services Health History Form

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

NAME: \_\_\_\_\_ LEISURE ACTIVITIES: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

Allergies: List any medication(s) you are allergic to: \_\_\_\_\_  
Are you latex sensitive? **YES NO** List any other allergies we should know about. \_\_\_\_\_  
Have you declared the Advanced Clinical of Do Not Resuscitate? **YES NO**

Please check (x) any of the following whose care you're under

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Medical doctor (MD) | <input type="checkbox"/> Psychiatrist/Psychologist | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Osteopath (DO)      | <input type="checkbox"/> Physical Therapist        | _____                                |
| <input type="checkbox"/> Dentist             | <input type="checkbox"/> Chiropractor              |                                      |

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.): \_\_\_\_\_  
\_\_\_\_\_

Have you ever been diagnosed as having any of the following conditions?

- |   |                                     |
|---|-------------------------------------|
| <b>YES NO</b> Cancer. If YES, describe what kind    | <b>YES NO</b> Heart Problems        |
| <b>YES NO</b> High Blood Pressure                   | <b>YES NO</b> Circulation Problems  |
| <b>YES NO</b> Asthma                                | <b>YES NO</b> Emphysema/Bronchitis  |
| <b>YES NO</b> Chemical Dependency (i.e. alcoholism) | <b>YES NO</b> Thyroid Problems      |
| <b>YES NO</b> Diabetes                              | <b>YES NO</b> Multiple Sclerosis    |
| <b>YES NO</b> Rheumatoid Arthritis                  | <b>YES NO</b> Other Arthritic Cond. |
| <b>YES NO</b> Depression                            | <b>YES NO</b> Hepatitis             |
| <b>YES NO</b> Tuberculosis                          | <b>YES NO</b> Stroke                |
| <b>YES NO</b> Kidney Disease                        | <b>YES NO</b> Anemia                |
| <b>YES NO</b> Epilepsy                              | <b>YES NO</b> Other _____           |

- |  |               |
|--|---------------|
| During the past month have you been feeling down, depressed or hopeless?             | <b>YES NO</b> |
| During the past month has your interest or pleasure in doing things decreased?       | <b>YES NO</b> |
| Do you ever feel unsafe at home or has anyone hit or tried to injure you in any way? | <b>YES NO</b> |
| FOR WOMEN: Are you currently pregnant or think you might be pregnant?                | <b>YES NO</b> |



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Please list any surgeries or other conditions for which you have been hospitalized, including the **approximate** date and reason for the surgery or hospital:

<u>DATE</u>		<u>REASON FOR HOSPITALIZATION</u>	
1.	_____	2.	_____
3.	_____	4.	_____
5.	_____	6.	_____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and **approximate** date of injury.

DATE	INJURY	DATE	INJURY
_____	_____	_____	_____
_____	_____	_____	_____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

<b>YES</b>	<b>NO</b>	Diabetes	<b>YES</b>	<b>NO</b>	Cancer
<b>YES</b>	<b>NO</b>	Tuberculosis	<b>YES</b>	<b>NO</b>	Arthritis
<b>YES</b>	<b>NO</b>	Heart Disease	<b>YES</b>	<b>NO</b>	Anemia
<b>YES</b>	<b>NO</b>	High Blood Pressure	<b>YES</b>	<b>NO</b>	Headaches
<b>YES</b>	<b>NO</b>	Stroke	<b>YES</b>	<b>NO</b>	Epilepsy
<b>YES</b>	<b>NO</b>	Kidney Disease	<b>YES</b>	<b>NO</b>	Mental Illness
<b>YES</b>	<b>NO</b>	Alcoholism (chemical dependency)			

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

<b>YES</b>	<b>NO</b>	Aspirin	<b>YES</b>	<b>NO</b>	Tylenol
<b>YES</b>	<b>NO</b>	Advil/Motrin/Ibuprofen	<b>YES</b>	<b>NO</b>	Laxatives
<b>YES</b>	<b>NO</b>	Decongestants	<b>YES</b>	<b>NO</b>	Antihistamines
<b>YES</b>	<b>NO</b>	Antacid	<b>YES</b>	<b>NO</b>	Vitamins/Minerals/Supp.
<b>YES</b>	<b>NO</b>	Other _____			

Please list any PRESCRIPTION medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1.	_____	2.	_____	3.	_____
4.	_____	5.	_____	6.	_____

How much caffeinated coffee or caffeine containing beverages do you drink per day? \_\_\_\_\_

How many packs of cigarettes do you smoke a day? \_\_\_\_\_

How many days per week do you drink alcohol? \_\_\_\_\_

If one drink equals one beer or glass of wine, how much do you drink at an average setting? \_\_\_\_\_

Have you recently noted:

<b>YES</b>	<b>NO</b>	Weight Loss/Gain	<b>YES</b>	<b>NO</b>	Nausea/Vomiting
<b>YES</b>	<b>NO</b>	Fatigue	<b>YES</b>	<b>NO</b>	Weakness
<b>YES</b>	<b>NO</b>	Fever/Chills/Sweats	<b>YES</b>	<b>NO</b>	Numbness or Tingling

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date