HARRIS REGIONAL HOSPITAL SWAIN COMMUNITY HOSPITAL

Name: _____ Today's Date: _____

PAST MEDICAL HISTORY:

Are you seeing anyone else for **THIS** problem?

[ ] Acupuncturist [ ] Cardiologist [ ] Chiropractor
[ ] ENT/ Otolaryngologist [ ] Massage Therapist [ ] Neurologist
[ ] OB/GYN [ ] Orthopedist [ ] Osteopath
[ ] Podiatrist [ ] Primary Care Physician/Pediatrician
[ ] Rheumatologist Other: _____

Have you had any of the following testing or services for **this** injury?

[ ] X-ray [ ] MRI [ ] CT scan [ ] Bone Scan
[ ] Doppler Study [ ] EMG [ ] Nerve Conduction Velocity

Please check if you have had any of the following:

[ ] Shortness of breath	[ ] High blood pressure	[ ] Headaches/ migraines
[ ] Fever/ Chills/ Night sweats	[ ] Low blood pressure	[ ] Stroke/ TIA
[ ] Nausea/ Vomiting	[ ] Chest pain/ angina/ palpitation	[ ] Parkinson's disease
[ ] Unexplained weight changes	[ ] Heart problems/ disease	[ ] Multiple Sclerosis
[ ] Numbness/ tingling	[ ] Heart attack	[ ] Alzheimer's disease/ dementia
[ ] Loss of energy/ fatigue	[ ] Heart surgery	[ ] Traumatic Brain Injury
[ ] Swollen lymph nodes	[ ] Pacemaker	[ ] Seizures/ Epilepsy
[ ] Weakness	[ ] Heart races/ skips beats	[ ] Tremors
	[ ] Blood clot/ DVT	[ ] Confusion/ Memory loss
[ ] Cancer: _____	[ ] Poor circulation	[ ] Poor balance/ recent falls
[ ] Diabetes/ High blood sugar	[ ] Asthma/ wheezing	[ ] Dizziness/ Vertigo
[ ] Low blood sugar	[ ] COPD/ Emphysema	
[ ] Osteoarthritis/ joint pain	[ ] Persistent cough	[ ] Change in bowel/ bladder
[ ] Osteoporosis	[ ] Fainting/ blacking out	[ ] Incontinence
[ ] Rheumatoid arthritis		[ ] Change in menstruation
[ ] Fibromyalgia	[ ] Raynaud's/ cold sensitivity	[ ] Anemia
	[ ] Gastrointestinal problems	[ ] Poor sensation
[ ] Hepatitis/ liver disease	[ ] Ulcers	[ ] Peripheral neuropathy
[ ] Kidney disease	[ ] Hernia	[ ] Skin problems
[ ] Abdominal pain	[ ] Gout	[ ] Depression/ anxiety
[ ] Low/ High thyroid	[ ] Difficulty swallowing	Tobacco products user? Yes No
[ ] High cholesterol	[ ] Change in appetite	Do you Smoke? Yes No
Other:	[ ] Heartburn/ indigestion	Are you pregnant? Yes No

Have you had **any** Physical, Occupational, or Speech Therapy since January 1st this calendar year? ( ) Yes ( ) No

Where? (◯) Outpatient/ Private/ Sports (◯) Inpatient/ Hospital
(◯) Skilled Nursing/ Assisted Living (◯) Home Health

Date of Injury: _____ Is this a work-related injury? ( ) Yes ( ) No

Date of Surgery: _____

MEDICATIONS: List all medications, over-the-counter, herbal supplements including dosage that you take on a regular basis: **We can copy your medication list*

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

ALLERGIES: List all known allergies including latex, adhesive tape, or medications

1._____ 2._____
3._____ 4._____

List all previous hospitalizations including operations, illnesses, and injuries:

_____ YEAR _____
_____ YEAR _____
_____ YEAR _____

Are you: (◯) Left-handed (◉) Right-handed

Occupation: _____ (list occupation)

(◯) Full Time (◯) Unemployed/ disabled (◉) Homemaker
(◯) Part Time (◯) Retired (◯) Student: _____

Highest level of education completed: (◯) Student, current
(◯) Some Middle/ High school (◯) High-school diploma/equivalent
(◯) Associates' degree (◯) Bachelor's degree (◉) Post-graduate

Living Environment:

Your home: (◯) Single-level home (◯) Multi-level home
(◯) Apartment/ Condo (◉) Assisted Living (◯) Ramp

How many steps to enter your home? _____

Does your stairs have hand rails? (◯) Yes (◉) No

How many steps are inside your home? _____

Whom do you live with:

(◯) Alone (◉) Spouse only (◯) Spouse and children

(◯) Parents/ family (◯) Other: _____

Do you have any person assisting you with your self-care, shopping, or other daily activities? ( ) Yes ( ) No

Do you use any assistive devices for hearing, seeing, etc?

(◯) Glasses (◯) Hearing Aid (◉) Other: _____

Lifestyle Questionnaire:

How do you rate your Health? (◯) Good (◉) Fair (◯) Poor

Emotional Health? (◯) Good (◉) Fair (◯) Poor

Eating Habits? (◯) Good (◉) Fair (◯) Poor

Sleeping Patterns? (◯) Good (◉) Fair (◯) Poor

Energy Level? (◯) Good (◉) Fair (◯) Poor

What is your knowledge of exercise and fitness? (◯) Good (◉) Fair (◯) Poor

How often do you exercise per week? (◯) greater than 3 (◉) 3 (◯) less than 3

Do you have any cultural or religious considerations which may impact your treatment? ( ) No ( ) Yes, _____

Are you being threatened or hurt by anyone? ( ) Yes ( ) No

Have you recently had thoughts of harming yourself or others? ( ) Yes ( ) No

Fall Risk Screening:

Have you fallen in the last 12 months? ( ) Yes ( ) No

How many times? _____

Do you feel unsteady when standing or walking? ( ) Yes ( ) No

Do you use any assistive device or assistance to help with walking and/or mobility? (◯) Rolling Walker (◉) Hemi-walker

(◯) Single Point Cane (◉) Quad Cane (◯) Crutches

(◉) Wheelchair, manual (◯) Wheelchair, powered

(◉) Prosthesis (◯) Other: _____

Please return completed form to Physical & Occupational Therapy.