2	<b>Emerson Hospital</b>
0	Emerson rospitai

### **CENTER FOR SPORTS REHAB AND SPECIALTY SERVICES**

PATIENT ID					

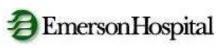
#### **HEALTH QUESTIONNAIRE**

What is the reason your doctor ha	as referred you?							
Describe your current symptoms								
Duration of current symptoms								
Have you received any diagnostic testing for this current condition: Yes No								
What type of testing have you red	•			BONE SCAN	EMG			
Where was the test performed?_					2.0.0			
Describe to the best of your know	leage the results of the testil	ng:						
Are you being hurt or made to fee	el afraid? Yes NO							
Please X next to any condition								
High Blood Pressure	Diabetes	unoning ma		Bladder Incontin	ence			
Heart Attack	Frequent Urination		Painful U					
Chest Pain	Excessive Thirst		Stress In	continence				
Stroke								
Angina	Impaired Vision							
Pacemaker	Impaired Hearing		Parkinson's					
	Dizziness / falls		Polio					
Respiratory Problems			Post Polio					
Asthma	History of Cancer		Multiple Sclerosis					
Shortness of Breath	Radiation		<u> </u>					
Lung Disease	Chemotherapy		Depression					
Smoking								
Persistent Cough			Fibromya					
Discourage in Authorities		Difficulty Swallowing						
Rheumatoid Arthritis	Heart burn / Reflux		Chronic Pain Headaches / Inc. Freq.					
Lupus Scleroderma	Arthritis		неадасп	es / inc. Freq.				
Reynaud's	Osteoporosis		Abnormal Weight gain / loss					
Reynaud S	Osteopenia		General Fatigue					
Thyroid			Generali	atigue				
THYTOIG	Come pain / Stimiess							
MRSA	Pregnant							
C-Diff								
***Have you received any therapy services this calendar year? Yes No Circle which services(s) PT OT ST Date:								
Have you received any therap				Date:				

NOTE: YOUR INSURANCE MAY OR MAY NOT COVER PHYSICAL THERAPY. PLEASE CHECK WITH YOUR INSURANCE PROVIDER PRIOR TO BEGINNING PHYSICAL THERAPY TO VERIFY YOUR COVERAGE.

Je 1 of 2

Rev (



# CENTER FOR SPORTS REHAB AND SPECIALTY SERVICES

PATIENT ID

#### **HEALTH QUESTIONNAIRE**

#### **PROBLEM LIST**

Medical F	Problems	
	Surgeon	Proc.

Date	Problem	Date	Problem

# **Surgical Procedures/Hospitalizations**

Date	Problem	Date	Problem

## **Medications**

Medication	Dose	e/Frequency	D/C	Date	Medication	Dose/	Frequency	D/C	Date

Allergies Latex: 

Yes 

No

Medication/Allergen	Reaction