

Welcome to our office and thank you for allowing us to help you!

### Medical History Questionnaire – Adult

If you are currently receiving Home Health Services please see the front desk immediately.

| Physician Information  | Acknowledgement and Consent for Oral Disclosure of Protected Health Information   |           |      |                            |   |               |   |              |  |
|--|---|-----------|------|----------------------------|---|---------------|---|--------------|--|
| Primary Care Physician's Name _____<br>Fax _____ Phone _____   | <p>_____ This notice applies to treatment you may receive at Shands Rehab Center at Magnolia Parke.</p> <p>_____ We understand your medical information is personal and we are committed to protecting your medical information. Our providers often discuss your rehabilitation care with you while receiving therapy services at Shands Rehab Center.</p> <p>_____ At times, even though reasonable precautions are instituted, other patients and / or health care providers may overhear our discussions.</p> <p>_____ By signing below, I acknowledge that I will be treated in a joint treatment setting. I understand that if at any time I wish to discontinue treatment in this setting or become uncomfortable with this communication, I will immediately inform my health care provider.</p> <p><i>I have read and initialed the above policies and agree to work with Shands Rehab Center to meet my rehab needs.</i></p> <p>_____</p>   |           |      |                            |   |               |   |              |  |
| Patient Information  |   |           |      |                            |   |               |   |              |  |
| Patient's Name _____<br>Social Security Number _____<br>Address _____<br>City _____ State _____ Zip Code _____<br>Home Phone: ( _____ ) _____<br>Cell Phone: ( _____ ) _____<br>Work Phone: ( _____ ) _____<br>Email Address _____<br><i>In case of emergency contact:</i><br>Name/Relationship _____<br>Phone: ( _____ ) _____<br>General: <input type="checkbox"/> Male <input type="checkbox"/> Female DOB ____/____/____<br>Age _____ Height _____ Weight _____<br>Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic<br><input type="checkbox"/> Asian <input type="checkbox"/> Other _____<br>Work Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled<br><input type="checkbox"/> Retired <input type="checkbox"/> Student<br>If employed, type of job? _____<br>Who lives in your house who can take care of you or for whom do you have to care for? _____<br>Is an ATTORNEY handling your case? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, who? _____ |   |           |      |                            |   |               |   |              |  |
| Insurance Information  |   |           |      |                            |   |               |   |              |  |
| Primary Insurance:<br>Insurance Name _____<br>Policy # _____ Group # _____<br>Phone: ( _____ ) _____<br>Secondary Insurance (CMS, DEI, OTHER):<br>Insurance Name _____<br>Policy # _____ Group # _____<br>Case Coordinator's Name _____<br>Phone: ( _____ ) _____  | <table border="1"><thead><tr><th>Signature</th><th>Date</th></tr></thead><tbody><tr><th>Lifestyle / Social History</th></tr><tr><td><input type="checkbox"/> Tobacco Use: Cigarettes: _____ packs/day x _____ years<br/>Other tobacco use _____<br/><input type="checkbox"/> Alcohol Use: Beer/Wine: _____ drinks per week<br/>Shots of Liquor: _____ shots per week<br/>Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed<br/>What is your normal sleeping position?<br/><input type="checkbox"/> Stomach <input type="checkbox"/> Sidelying <input type="checkbox"/> Back</td></tr><tr><th>Special Needs</th></tr><tr><td>Do you have any special needs to be considered prior to or during treatment (<i>please check all that apply</i>)?<br/><input type="checkbox"/> Language <input type="checkbox"/> Cultural <input type="checkbox"/> Cognitive <input type="checkbox"/> Glasses/Hearing<br/><input type="checkbox"/> Physical <input type="checkbox"/> Religious <input type="checkbox"/> Emotional <input type="checkbox"/> Reading/Writing<br/><input type="checkbox"/> Financial <input type="checkbox"/> Other _____<br/>Are you or your family interested in learning about your special need(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr><tr><th>Fall History</th></tr><tr><td><b>You MUST answer these questions.</b><br/>Have you fallen in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>Do you feel you are at risk for falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr></tbody></table> | Signature | Date | Lifestyle / Social History | <input type="checkbox"/> Tobacco Use: Cigarettes: _____ packs/day x _____ years<br>Other tobacco use _____<br><input type="checkbox"/> Alcohol Use: Beer/Wine: _____ drinks per week<br>Shots of Liquor: _____ shots per week<br>Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed<br>What is your normal sleeping position?<br><input type="checkbox"/> Stomach <input type="checkbox"/> Sidelying <input type="checkbox"/> Back | Special Needs | Do you have any special needs to be considered prior to or during treatment ( <i>please check all that apply</i> )?<br><input type="checkbox"/> Language <input type="checkbox"/> Cultural <input type="checkbox"/> Cognitive <input type="checkbox"/> Glasses/Hearing<br><input type="checkbox"/> Physical <input type="checkbox"/> Religious <input type="checkbox"/> Emotional <input type="checkbox"/> Reading/Writing<br><input type="checkbox"/> Financial <input type="checkbox"/> Other _____<br>Are you or your family interested in learning about your special need(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No | Fall History | <b>You MUST answer these questions.</b><br>Have you fallen in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Do you feel you are at risk for falling? <input type="checkbox"/> Yes <input type="checkbox"/> No |
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| <b>You MUST answer these questions.</b><br>Have you fallen in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Do you feel you are at risk for falling? <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |           |      |                            |   |               |   |              |  |

Shands  
RehabCenters



TH0002

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at Magnolia Parke  
4740 NW 39th Place, Suite D Gainesville, FL 32606

Medical History Questionnaire (Adult) (page 1 of 2)

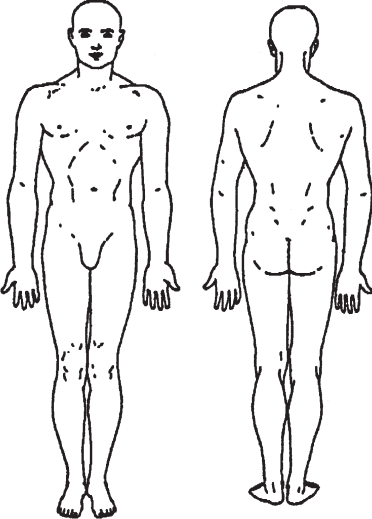
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PS105336

Patient Name:

Patient MR #:

Patient Date of Birth:

| Past Medical History   | Family History   |                 |                 |              |   |   |   |   |   |   |    |            |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
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| <p><b>Check the box next to any illness(es) that applies YOU:</b></p> <input type="checkbox"/> Cancer <input type="checkbox"/> Asthma <input type="checkbox"/> Alcoholism <input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Kidney Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Epilepsy <input type="checkbox"/> Birth Defects<br><input type="checkbox"/> Emphysema <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes <input type="checkbox"/> Ulcers<br><input type="checkbox"/> Other _____   | <p><b>Check the box next to any disease(s) diagnosed in YOUR BLOOD RELATIVES:</b> <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease<br/> <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Other Arthritis<br/> <input type="checkbox"/> Bleeding Problems <input type="checkbox"/> Gout <input type="checkbox"/> Other _____</p>  |                 |                 |              |   |   |   |   |   |   |    |            |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
| Previous Surgeries   | Pain Assessment / Function / Goals   |                 |                 |              |   |   |   |   |   |   |    |            |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
| <p><b>Check the box next to any surgical procedure(s) YOU have had:</b></p> <input type="checkbox"/> Tonsils <input type="checkbox"/> Heart <input type="checkbox"/> Ovaries <input type="checkbox"/> Stomach <input type="checkbox"/> Appendix<br><input type="checkbox"/> Uterus <input type="checkbox"/> Prostate <input type="checkbox"/> Colon <input type="checkbox"/> Thyroid <input type="checkbox"/> Kidney<br><input type="checkbox"/> Other Surgeries _____<br><input type="checkbox"/> Extremity Surgeries _____   | <p><b>Past level of function BEFORE this problem began, your normal activities were:</b> <input type="checkbox"/> Normal and unrestricted<br/> <input type="checkbox"/> Minimally restricted <input type="checkbox"/> Moderately restricted<br/> <input type="checkbox"/> Severely restricted <input type="checkbox"/> Only heavy activities restricted</p> <p><b>Present level of function NOW with your current condition, your normal activities are:</b> <input type="checkbox"/> Normal and unrestricted<br/> <input type="checkbox"/> Minimally restricted <input type="checkbox"/> Moderately restricted<br/> <input type="checkbox"/> Severely restricted <input type="checkbox"/> Only heavy activities restricted</p>  |                 |                 |              |   |   |   |   |   |   |    |            |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
| ALLERGIES  | <p><b>Your current pain:</b> Indicate on the diagram below the location and nature of your <b>CURRENT</b> pain according to the following symbols:</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="width: 45%;"> <p>(XXX = dull/aching pain;<br/>           ^^^ = sharp pain;<br/>           +++ = pins and needles;<br/>           === = numbness)</p> <p><b>DO NOT</b> indicate areas of pain which are not related to your present problem.</p> </div> <div style="width: 45%; text-align: center;">  </div> </div>  |                 |                 |              |   |   |   |   |   |   |    |            |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
| <p><b>Do YOU have any allergies to:</b> <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa<br/> <input type="checkbox"/> Latex <input type="checkbox"/> Other _____</p>  |  |                 |                 |              |   |   |   |   |   |   |    |            |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
| Current Problem  |  |                 |                 |              |   |   |   |   |   |   |    |            |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
| <p><b>Explain current problem</b> _____<br/>         Injury Date: ____/____/____ Surgery Date: ____/____/____<br/>         How did it happen? _____<br/>         What treatment(s) have you had for this <b>CURRENT</b> problem?<br/> <input type="checkbox"/> Surgery <input type="checkbox"/> Injection <input type="checkbox"/> Splinting / Bracing<br/> <input type="checkbox"/> Chiropractic Treatment: # of visits _____<br/> <input type="checkbox"/> Massage Therapy: # of visits _____<br/>         When are your problems most severe?<br/> <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Consistent all day<br/>         Have you had <b>THIS PROBLEM</b> before: <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         If yes, when _____<br/>         Previous treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         If yes, what _____<br/>         Did you regularly exercise prior to this problem: <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         What / how often _____<br/>         Are your complaints affecting your ability to exercise or generally be active? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         Do you frequently feel pain in your chest / heart? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         Do you know of any other reason why you should not do physical activity? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |  |                 |                 |              |   |   |   |   |   |   |    |            |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
| Medications  | <p><b>PAIN RATING on a scale of 0 - 10</b> (0 = no pain; 10 = worst imaginable):<br/> <i>Please check number that applies.</i></p> <p><b>How would you rate the INTENSITY of your pain?</b>      <b>Intensity is:</b></p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 10%;">Now</td> <td style="width: 10%;">0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> <td style="width: 10%; text-align: right;">Increasing</td> </tr> <tr> <td>Worst Day</td> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> <td style="text-align: right;">Decreasing</td> </tr> <tr> <td>Best Day</td> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> <td style="text-align: right;">Unchanged</td> </tr> </table> <p><b>How STRESSFUL is the pain you are feeling?</b>      <b>Distress is:</b></p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 10%;">Now</td> <td style="width: 10%;">0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> <td style="width: 10%; text-align: right;">Increasing</td> </tr> <tr> <td>Worst Day</td> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> <td style="text-align: right;">Decreasing</td> </tr> <tr> <td>Best Day</td> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> <td style="text-align: right;">Unchanged</td> </tr> </table> <p>What activities make your pain <b>WORSE</b>? _____<br/>         What activities make your pain <b>BETTER</b>? _____</p> <p><b>Your goals for treatment are:</b><br/>         _____<br/>         _____</p> | Now             | 0               | 1            | 2 | 3 | 4 | 5 | 6 | 7 | 8  | 9          | 10 | Increasing | Worst Day | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Decreasing | Best Day | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Unchanged | Now | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Increasing | Worst Day | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Decreasing | Best Day | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Unchanged |
| Now  | 0  | 1               | 2               | 3            | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Increasing |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
| Worst Day  | 0  | 1               | 2               | 3            | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Decreasing |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
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| Best Day   | 0  | 1               | 2               | 3            | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Unchanged  |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
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| Medication Name  | Date Started   | Medication Name | Date Started    |              |   |   |   |   |   |   |    |            |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
|  |  |                 |                 |              |   |   |   |   |   |   |    |            |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
|  |  |                 |                 |              |   |   |   |   |   |   |    |            |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
|  |  |                 |                 |              |   |   |   |   |   |   |    |            |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
|  |  |                 |                 |              |   |   |   |   |   |   |    |            |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
|  |  |                 |                 |              |   |   |   |   |   |   |    |            |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
|  |  |                 |                 |              |   |   |   |   |   |   |    |            |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
| <p><b>Please elaborate about any medications YOU are currently taking:</b></p>   |  |                 |                 |              |   |   |   |   |   |   |    |            |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |
| <p><b>Patient Signature</b> _____</p>  | <p><b>Date</b> _____</p>   |                 |                 |              |   |   |   |   |   |   |    |            |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |     |   |   |   |   |   |   |   |   |   |   |    |            |           |   |   |   |   |   |   |   |   |   |   |    |            |          |   |   |   |   |   |   |   |   |   |   |    |           |

Patient Name: \_\_\_\_\_  
 Patient MR #: \_\_\_\_\_  
 Patient Date of Birth: \_\_\_\_\_