1PA

Keck Center for Outpatient Therapy Services
Therapy Questionnaire

Today's Date: _____Your Age: _____Your Occupation_____

1. Do you currently have or have you ever had the following? If so, please explain.

High Blood Pressure	Yes	No	Breathing Problems/Asthma	Yes	No
Heart Trouble / Pacemaker	Yes	No	Fractures / Osteoporosis	Yes	No
Circulation Problems	Yes	No	Stroke	Yes	No
Seizures	Yes	No	Arthritis	Yes	No
Diabetes	Yes	No	Depression / Anxiety	Yes	No
Dizziness	Yes	No	Metal Implants	Yes	No
Allergies	Yes	No	Cancer	Yes	No
Bowel/Bladder problems	Yes	No	Memory Impairment	Yes	No
Weight loss/gain	Yes	No	Confusion	Yes	No
Currently Pregnant	Yes	No	Hearing loss	Yes	No
Allergies to Heat or Ice	Yes	No	Sleep problems	Yes	No

2. Describe the problem that brings you into therapy _____
3. When did your present problem start? _____
4. Have you had any previous problems in this area? _____
5. What goals can we help you achieve with therapy? _____
_____
6. Have you received therapy already this year? If so, what type? _____
7. Do you exercise regularly? Y/N If so, what is your routine? _____
8. Have you fallen in the past 30 days? Y/N
9. How do you learn best? Demonstration / paper handouts / verbal instruction *(please circle)*

Patient Label

Cottage Rehabilitation Hospital

Keck Center for Outpatient Therapy Services

THERAPY QUESTIONNAIRE

Form# NS1504 (Rev. 06/18)

PLEASE PROVIDE THE FOLLOWING INFORMATION

Current Medications (feel free to add a page if needed)	

Allergies/Adverse Reactions to Medications	

Major Medical Problems	**Date**

Surgeries/Invasive Procedures	**Date**