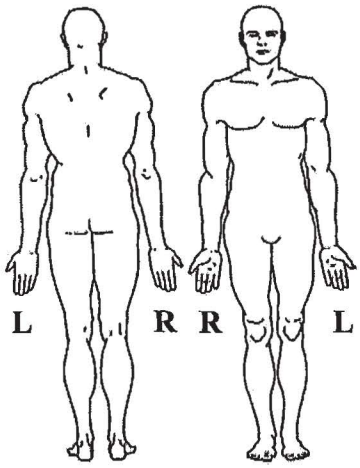
1. Describe the problem that brings you to this appointment and use the diagram to the right to identify problem areas.



_____

_____

2. When did this start? _____
3. How did it happen? (unknown, injury, surgery) _____

_____

4. What makes it better? _____
5. What makes it worse? _____
6. Please list any testing, imaging (x-ray, MRI, etc), or prior treatment for this problem.

_____

7. On a scale from 0-10 (0 = no pain, 10 = worst imaginable pain), how would you rate your pain?
   Current _____, Best _____, Worst _____
8. What activities are you having difficulty with because of your problem?

_____

_____

9. What is your occupation? _____
10. Have you fallen in the past 12 months? ❑ No ❑ Yes, how many times? _____
    Any injuries? ❑ No ❑ Yes
11. Why are falls occurring? _____
12. What are your goals for therapy? _____

_____

_____

Social History: (please check all that apply)

❑ Exercise routine _____

❑ Tobacco use (packs per day) _____

❑ Alcohol use (drinks per week) _____

❑ Feel unsafe in your home or residence

CarePartners Outpatient Services Asheville, NC

Outpatient Subjective/Medical History

Patient Information / Label

Please check &/or circle if you have EVER been diagnosed with any of the following. Use lines to describe further.

Musculoskeletal
- ❑ Muscle/joint pain _____
- ❑ Rheumatoid/osteoarthritis
- ❑ Osteoporosis/osteopenia
- ❑ Scoliosis
- ❑ Fibromyalgia
- ❑ Fracture/broken bone

Neurological
- ❑ Neuropathy _____
- ❑ ALS
- ❑ Multiple sclerosis
- ❑ Parkinson's disease
- ❑ Epilepsy/seizures
- ❑ Post-Polio syndrome
- ❑ Spinal cord injury
- ❑ Stroke/TIA
- ❑ Brain injury
- ❑ Muscular dystrophy
- ❑ Other developmental disorder _____

Cardiovascular/Pulmonary
- ❑ Blood pressure issues _____
- ❑ Heart issues _____
- ❑ Breathing issues _____
- ❑ Blood clots _____
- ❑ Lymphedema _____
- ❑ Anemia/blood disorder

Integumentary/Skin
- ❑ Rashes/bites _____
- ❑ Wounds/pressure ulcers

Communication/Cognition
- ❑ Vision issues (cataract, glaucoma, etc)
  Other: _____
- ❑ Hearing issues _____
- ❑ Speech issues _____
- ❑ Alzheimer's/dementia
- ❑ Memory/focus issues (ADD, ADHD, etc)

Other
- ❑ Diabetes I/II
- ❑ Kidney issues _____
- ❑ Bowel or bladder issues
- ❑ Anxiety/depression
- ❑ Psychological issues _____
- ❑ Headaches
- ❑ Sleep issues _____
- ❑ Currently or possibly pregnant
- ❑ Decreased appetite
- ❑ Unexplained weight loss/gain
- ❑ Chewing/swallowing difficulty
- ❑ Prosthetic/implants
- ❑ Cancer _____
- ❑ Hepatitis
- ❑ HIV/AIDS
- ❑ TB or unexplained cough
- ❑ MRSA/infections

13. Please list all surgeries as well as radiation/chemotherapy treatments (including year).

_____

_____

14. Please list all prescription & over the counter medications you are taking. Check box if none ❑

_____

15. Please list any allergies (food, skin, or medication). _____

16. Please list individual(s) we may speak with about your medical condition. _____

_____

17. Is there any other medical, personal, or cultural information you want to share that may affect your care?

_____

_____

18. What is your preferred name? _____ Preferred pronoun? _____

Have you or a close contact traveled outside the US in the last 3 weeks? ❑ Yes ❑ No

Have you ever had TB or a positive TB skin test? ❑ Yes ❑ No

Recent close contact with a person who has TB or influenza or a contagious illness? ❑ Yes ❑ No

In the last 7 days have you experienced any of the following:

- ❑ Fever > 100.4 F
- ❑ Persistent cough (greater than 3 weeks)
- ❑ Night sweats
- ❑ Body aches
- ❑ Nasal congestion (not related to allergy/sinus infection)
- ❑ Shortness of breath
- ❑ Cough with blood production
- ❑ Unexplained weight loss
- ❑ Rash
- ❑ Cough (not related to COPD)
- ❑ Sore throat
- ❑ Fatigue
- ❑ Bed bugs ❑ Scabies ❑ Lice

Signature of person completing form & relationship to client: _____ Date/Time: _____

Therapist name: _____ Date/Time: _____

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