Hands On Hands Rehabilitation Center, Inc.
Health History Questionnaire

Date:_____

All questions contained in this questionnaire are strictly confidential and will become a part of your medical records.

Name:_____ DOB:_____(Month/Day/Year)

Are you currently receiving rehab treatments with:

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Home Health Services

Have you had or currently have any of the following:

☐ Cancer ☐ Seizures ☐ Pregnant (current) ☐ Diabetes ☐ Parkinson's Disease

☐ MS ☐ Heart Problems ☐ Pacemaker ☐ Fibromyalgia

☐ Surgeries:_____ ☐ Broken Bones _____

_____ _____

☐ Other (anything else that might be pertinent in your health history): _____

_____

If yes to any of the above, please explain:_____

_____

_____

Please list any allergies: (Latex, Rubber Gloves etc. What happens?):_____

_____

Health Habits and Personal; Safety:

Caffeine: ☐ None ☐ Coffee ☐ Tea ☐ Cola # of cups/cans per day_____

BMI: Height: _____(_____in.'s) Weight: _____

How often do you drink alcohol? ☐ Never ☐ Monthly ☐ 2-4 x Month ☐ 2-3 x Week ☐ 4 / more x wk

# of drinks per day: ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more

How often do you have 6 or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Almost daily

Do you smoke Tobacco? ☐ No ☐ Yes ☐ Chew # per day:_____

Have you considered quitting? _____ What is stopping you from Quitting?_____

For Females Only: Are you currently pregnant? ☐

Are you considering becoming pregnant? ☐

Are you currently breastfeeding? ☐

Hands On Hands Rehabilitation Center, Inc.
Patients Medication History

The medications you take are a part of your health information. Please fill out this form (or have your caregiver complete it) and discuss it with your therapist. If you need more space to list your medications, write on the back of this form.

Patient Name:_____ DOB:_____ Date:_____

CURRENT MEDICATIONS:

Prescription Drugs	Strength (such as 50 mg)	Directions (such as 2 tablets in the a.m.) Check box if taken as needed	PRN	Prescribed by Physician (name)
☐ Check if None				

OVER THE COUNTER MEDICATIONS: (such as aspirin)

Medication	Strength (such as 50 mg)	Directions (such as for headaches, taken as needed-PRN)
☐ Check if None		

HERBS, VITAMINS, MINERALS, SUPPLEMENTS: (such as St. Johns Wart, Omega)

Medication	Strength (such as 50 mg)	Directions (such as for headaches, taken as needed-PRN)
☐ Check if None		