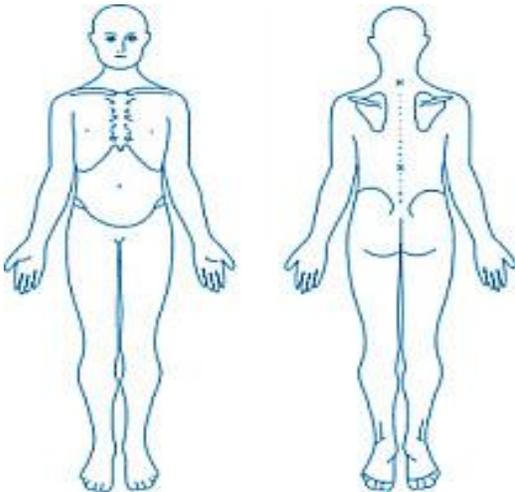




Health Status Survey

In order to help you return to full health and independence we would like to know about your current health status. All information provided will be kept confidential. Thank you for your time.

Name: _____ Date of Birth: ___/___/___/ Date: _____

<p>Current Issues</p> <div style="text-align: center;">  </div> <p style="text-align: center;">Please circle <input type="radio"/> your areas of concern</p>	<p>Work: Regular occupation: _____ Currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No Regular hours /duties <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Home: Are you performing your regular housekeeping duties? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Personal Care: Are you able to fully care for yourself? (dress, bathe, ect.) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Recreation: Are you participating in your normal recreation activities? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Regular recreation activities: _____ _____ _____</p>
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Health Status – please indicate if you currently have, or have had any of the following conditions listed below in the past.

<p>Infections:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Current</th> <th style="width: 10%; text-align: center;">Past</th> </tr> </thead> <tbody> <tr> <td>MRSA, VRE, C-Diff -----</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> <p>Medications:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Current</th> <th style="width: 10%; text-align: center;">Past</th> </tr> </thead> <tbody> <tr> <td>Blood thinners ----- (Cumadin/ Warfrin/Heparin/high dose Aspirin)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Cortico-steroids ----- (Prednisone)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Antidepressants -----</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Other: _____</td> <td></td> <td></td> </tr> </tbody> </table> <p>Women's Health:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>Are you pregnant -----</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>How many months? _____</td> <td></td> <td></td> </tr> <tr> <td>Other: _____</td> <td></td> <td></td> </tr> </tbody> </table>		Current	Past	MRSA, VRE, C-Diff -----	<input type="checkbox"/>	<input type="checkbox"/>		Current	Past	Blood thinners ----- (Cumadin/ Warfrin/Heparin/high dose Aspirin)	<input type="checkbox"/>	<input type="checkbox"/>	Cortico-steroids ----- (Prednisone)	<input type="checkbox"/>	<input type="checkbox"/>	Antidepressants -----	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____				Yes	No	Are you pregnant -----	<input type="checkbox"/>	<input type="checkbox"/>	How many months? _____			Other: _____			<p>Ears, nose, throat:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Current</th> <th style="width: 10%; text-align: center;">Past</th> </tr> </thead> <tbody> <tr> <td>Hearing loss -----</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Ringing in ears -----</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Smell/ taste issues -----</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Hoarseness -----</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Speech difficulty -----</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Other: _____</td> <td></td> <td></td> </tr> </tbody> </table> <p>Nervous system:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Current</th> <th style="width: 10%; text-align: center;">Past</th> </tr> </thead> <tbody> <tr> <td>Epilepsy/ seizures -----</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Stroke -----</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Other: _____</td> <td></td> <td></td> </tr> </tbody> </table>		Current	Past	Hearing loss -----	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears -----	<input type="checkbox"/>	<input type="checkbox"/>	Smell/ taste issues -----	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness -----	<input type="checkbox"/>	<input type="checkbox"/>	Speech difficulty -----	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____				Current	Past	Epilepsy/ seizures -----	<input type="checkbox"/>	<input type="checkbox"/>	Stroke -----	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
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General Health:

	Current	Past
Metal implants -----	<input type="checkbox"/>	<input type="checkbox"/>
Total joint replacements -----	<input type="checkbox"/>	<input type="checkbox"/>
Fractures/bone breaks -----	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness -----	<input type="checkbox"/>	<input type="checkbox"/>
Slurred speech -----	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing -----	<input type="checkbox"/>	<input type="checkbox"/>
Double vision -----	<input type="checkbox"/>	<input type="checkbox"/>
Sudden fainting -----	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sensation in the -----	<input type="checkbox"/>	<input type="checkbox"/>
Cancer -----	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss -----	<input type="checkbox"/>	<input type="checkbox"/>
Significant night pain -----	<input type="checkbox"/>	<input type="checkbox"/>
Numbness in the saddle area -----	<input type="checkbox"/>	<input type="checkbox"/>
Fever/chills -----	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats -----	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

Genitourinary system:

	Current	Past
Bladder infection -----	<input type="checkbox"/>	<input type="checkbox"/>
Bladder function change ----- (Frequency/ incontinence/retention)	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine -----	<input type="checkbox"/>	<input type="checkbox"/>
Change in sexual function -----	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

Endocrine system:

	Current	Past
Diabetes -----	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems -----	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

Skin:

	Current	Past
Wounds/ lesions/ rashes -----	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis -----	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive skin -----	<input type="checkbox"/>	<input type="checkbox"/>

Digestive system:

	Current	Past
Colitis/ IBS -----	<input type="checkbox"/>	<input type="checkbox"/>
Nausea -----	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting -----	<input type="checkbox"/>	<input type="checkbox"/>
GERD/heart burn -----	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool -----	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers -----	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

Respiratory system:

	Current	Past
Pain with cough/ sneeze -----	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough -----	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood -----	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath -----	<input type="checkbox"/>	<input type="checkbox"/>
Asthma -----	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

Cardiovascular:

	Current	Past
Bleeding disorder -----	<input type="checkbox"/>	<input type="checkbox"/>
High/low blood pressure -----	<input type="checkbox"/>	<input type="checkbox"/>
High blood cholesterol -----	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack -----	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain/ discomfort -----	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heart beat -----	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker -----	<input type="checkbox"/>	<input type="checkbox"/>
Leg/ankle swelling -----	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

I have none of the above and am in good health

Thank – you for your time
The Therapeutic Mobility team ☺