PT3

UnityPoint Health
Des Moines

Date of Next Physician Visit ____________________

Date of injury or onset of problem[3] ____________ How were you injured? ____________________

Age _____ Date of Birth[4] ________ Employer[6] ____________________ Occupation[7] ____________

Phone: Home ________________ Cell ________________ Work ________________

Describe current problem/body area involved ____________________

At the present time, would you say that your health is: ☐ Excellent ☐ Very good ☐ Fair ☐ Poor

Have you had any treatment or test for this injury/problem (Xray, MRI, EMG, etc) ____________

Have you ever had any previous therapy visits at home or as an outpatient this year? ____________

If Worker's Compensation: Contact name(s) ____________________

Phone ________________ Fax ________________

Case Manager or Company Nurse ____________________

Work related: ☐ Yes ☐ No Currently working: ☐ Yes ☐ No Restrictions: ☐ Yes ☐ No Describe ______

Medical History *(Please check all illnesses that apply):*

Blood pressure: ☐ High ☐ Low Abnormal weight: ☐ Loss ☐ Gain ☐ Heart disease/problems ☐ Diabetes

☐ Osteoporosis ☐ Pacemaker Year ______ ☐ Current/past pregnancy(ies) ☐ Bowel/bladder changes ☐ Seizures

☐ Cancer Type ________________ ☐ Other ____________________

Prior surgery(ies) ____________________

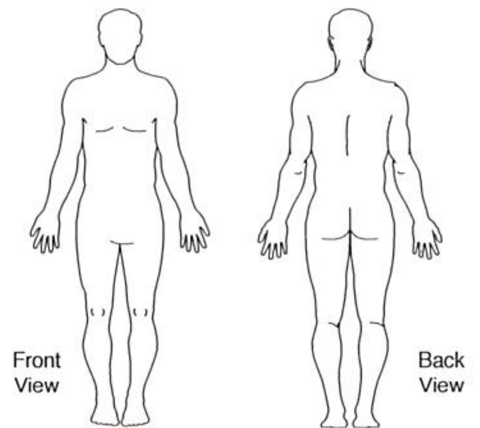
Please list any allergies: ____________________

Does your injury affect any of the following activities? *(please check all that apply)*

☐ Exercise ☐ Sitting ☐ Sleeping ☐ Stairs/curbs ☐ Standing ☐ Walking ☐ Driving ☐ Bathing ☐ Dressing

☐ Housework ☐ Cooking ☐ Other ____________________

Please shade your area(s) of greatest discomfort



What other symptoms have been associated with this condition?

☐ Grinding ☐ Giving away ☐ Tingling ☐ Nausea ☐ Dizziness

☐ Weakness ☐ Numbness ☐ Swelling

Circle pain now: 0 1 2 3 4 5 6 7 8 9 10

How often does it hurt? ____________________

What makes your symptoms worse? ____________________

____

What makes your symptoms better? ____________________

____

What are your goals for Therapy? ____________________

What do you do for exercise (frequency)? ____________________

PATIENT LABEL

4-2013 OM
THER 1002

Outpatient Questionnaire

ORD1

UnityPoint Health
Des Moines

Source of Medication list: (check all that apply). Include all prescription & non-prescription meds.

☐ Patient medication list ☐ Patient/family recall Other ______________________

Medication Name Include ALL Prescription & Non-Prescription Medications (include herbals, nutraceuticals, & OTCs)	**Dose**	**Route**	**Frequency**
☐ **Takes NO home medications**			
☐ **See attached medication list**			

Home Med. List: Outpatient Therapies *(Medication Reconciliation Form)*

Home Med. List: Outpatient Therapies *(Medication Reconciliation Form)*

Date & Name of Person Completing Information

____

____

Patient Label

Distribution: White/Chart

4-2013 OM
ORD 0257
O/PTherapies

Home Medication List:
Outpatient Therapies
(Medication Reconciliation Form)
Content Review: 06/2007