



\*Patient Questionnaire\*

### Therapy Medical Information

**If you have previously been seen by a UnityPoint Health provider, your therapist can access your electronic medical record. Please take a moment to answer these additional questions for our team to better assist you.**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**PLEASE MARK "YES" OR "NO"**

Are you receiving services from a Home Health Agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you fallen within the last 3 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you now, or could you possibly be pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you in a current relationship in which you have ever been hurt or threatened?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, would you like to speak with someone about this, or do you need resource information?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How do you prefer to learn? <input type="checkbox"/> Reading <input type="checkbox"/> Listening <input type="checkbox"/> Demonstration <input type="checkbox"/> Pictures/Visual		

***This information is complete and accurate to the best of my knowledge.***

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

