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 ______________________

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? ______________________

______________________________________

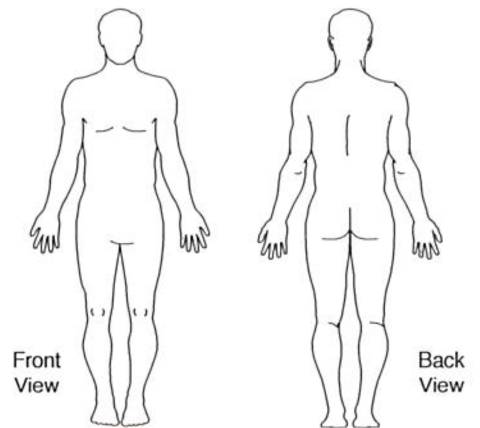
What makes your symptoms better? ______________________

______________________________________

What are your goals for Therapy? ______________________

What do you do for exercise (frequency)? ______________________

**Please shade your area(s) of greatest discomfort**




PATIENT LABEL



4-2013 OM
THER 1002

## Outpatient Questionnaire

ORD1

UnityPoint Health
Des Moines

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

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

☐ Patient medication list ☐ Patient/family recall Other ____________________

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