

Courage Center

Adult Health History Questionnaire

3915 Golden Valley Road
Minneapolis, MN 55422
763.588.0811

12400 Portland Ave S
Burnsville, MN 55337
952.898.5700

1460 Curve Crest Blvd
Stillwater, MN 55082
651.439.8283

146 North Lake Street
Forest Lake, MN 55025
651.464.5235

Last name: _____ First name: _____ MI: ___ Date: _____

Birthdate: _____ Medical diagnosis: _____

How well do you speak English? Fluently English understood Interpreter needed
If not English, what is your primary language:

Do you drive? Yes No If no, did you drive previously? Yes No

Are you right-handed left-handed

Where do you live?

- Private home Board and care/assisted living/group home
 Private apartment Long-term care facility (nursing home)
 Other:

After discharge from therapies, do you plan to remain in your current living situation?

Yes No If no, is there anything you would like your therapist to address with you prior to discharge?

With whom do you live?

- Alone Children (no other adults) Personal care attendant
 Spouse only Other adult(s) Other:
 Spouse and children Group Setting

Do you provide care for: A dependent child A dependent adult A pet

Are there any obstacles that prevent you from getting in or out of your home or moving around your home freely? Yes No If yes, please specify:

Work status: Working Retired Unemployed Disabled Stay-at-home parent
If working: Occupation Any restrictions?

Comfort in water: (For water therapy only) Are you: An independent swimmer
 Non-swimmer, but comfortable in chest deep water Afraid of/not comfortable in water

Are you interested in getting more information about: Driving program
 Recreational services Social services Support groups Vocational services

If female, are you: Pregnant Breast feeding

History of current problems: What is/are the primary reason(s) that brought you to Courage Center?

If related to a recent problem, when did the problem(s) begin? Month: _____ Year: _____

Did the problem(s) begin: Gradually After an accident
 After an illness After surgery

Are you currently experiencing pain? Yes No

What makes the problem(s) better? Medications Changing position Heat/cold Rest
 Other:

Have you been hospitalized in the past year? Yes No If yes, date:

Reason:

Have you ever had surgery? Yes No If yes, please describe and include dates:

_____ month: _____ year: _____
 _____ month: _____ year: _____
 _____ month: _____ year: _____

Medications: Please list any prescription medication and dosage. Attach list, if needed:

Do you take any non-prescription medications? *(Check all that apply):*

- | | | |
|------------------------------------------|-----------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Advil/Ibuprofen | <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Herbal supplements |
| <input type="checkbox"/> Aleve/Naproxyn | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Decongestants | <input type="checkbox"/> Other: |

Within the past year, have you had any of the following symptoms? *(Check all that apply):*

- | | | |
|-------------------------------------------------|---------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Coordination problems | <input type="checkbox"/> Loss of bowel/bladder control | <input type="checkbox"/> Swallowing difficulty |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Weakness of arms or legs |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Pain at night | <input type="checkbox"/> Weakness of face or voice |
| <input type="checkbox"/> Dizziness or blackouts | <input type="checkbox"/> Reduced speech intelligibility | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> Headaches | | <input type="checkbox"/> Word finding problems |
| <input type="checkbox"/> Joint pain or swelling | | <input type="checkbox"/> Other: |

Within the past year, have you had any of the following medical tests?

(Check all that apply):

- | | | |
|---------------------------------------|--------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Angiogram | <input type="checkbox"/> EKG (electrocardiogram) | <input type="checkbox"/> Spinal tap |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> EMG (electromyogram) | <input type="checkbox"/> Stress test (treadmill) |
| <input type="checkbox"/> Bone scan | <input type="checkbox"/> Myelogram | <input type="checkbox"/> Swallow study (videofluoroscopy) |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Neuropsychological evaluation | <input type="checkbox"/> X-rays |
| <input type="checkbox"/> CT scan | | |

Have you previously or are you now seeing anyone else for the problem(s)?

(Check all that apply):

- | | | |
|--------------------------------------------------|------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Neuropsychologist | <input type="checkbox"/> Physical therapist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Obstetrician/gynecologist | <input type="checkbox"/> Podiatrist |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Occupational therapist | <input type="checkbox"/> Primary care physician |
| <input type="checkbox"/> Internist | <input type="checkbox"/> Ophthalmologist/optometrist | <input type="checkbox"/> Rheumatologist |
| <input type="checkbox"/> Massage therapist | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Speech/language therapist |
| <input type="checkbox"/> Mental health counselor | <input type="checkbox"/> Osteopath | <input type="checkbox"/> Other: |

If checked above, please provide:

Name of provider:

Date of last visit:

Do you use? (check all that apply):

- | | | |
|------------------------------------------------------------------|-----------------------------------------------|---------------------------------|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Cane |
| <input type="checkbox"/> Hearing aids | <input type="checkbox"/> Motorized wheelchair | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Orthotics/Splints/Brace Type: | Vendor: | |
| <input type="checkbox"/> Augmentative communication system Type: | | |
| <input type="checkbox"/> Other: | | |

Are you having any difficulty in these functional areas? (Check all that apply):

Household:

- | | | |
|---------------------------------------------------------|------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Carrying | <input type="checkbox"/> Managing money/budget | <input type="checkbox"/> Sweep/mop/rake |
| <input type="checkbox"/> Cooking | <input type="checkbox"/> Pushing/pulling | <input type="checkbox"/> Vacuuming |
| <input type="checkbox"/> Laundry | <input type="checkbox"/> Reaching overhead | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Lifting more than _____ pounds | <input type="checkbox"/> Shopping | |

Psychosocial:

- | | | |
|----------------------------------------------|-------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Anger management | <input type="checkbox"/> Depression | <input type="checkbox"/> Relationships |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Inappropriate behavior | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Pain management | |

Personal:

- | | | |
|---------------------------------------|-------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Eating | <input type="checkbox"/> Sexual relations |
| <input type="checkbox"/> Computer use | <input type="checkbox"/> Grooming | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Handcrafts/leisure interests | <input type="checkbox"/> Sports |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Managing medications | <input type="checkbox"/> Other: |

Communication/Cognition:

- | | | |
|--------------------------------------|------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Attention | <input type="checkbox"/> Memory | <input type="checkbox"/> Speaking |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Orientation | <input type="checkbox"/> Swallowing |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Problem solving | <input type="checkbox"/> Understanding |
| <input type="checkbox"/> Initiation | <input type="checkbox"/> Reading | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Other: | | |

Mobility:

- | | | |
|---------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Bending down | <input type="checkbox"/> Getting in/out of car | <input type="checkbox"/> Getting up from floor |
| <input type="checkbox"/> Stairs | <input type="checkbox"/> Getting in/out of bed | <input type="checkbox"/> Getting up from chair/toilet |
| <input type="checkbox"/> Sitting more than _____ minutes | | |
| <input type="checkbox"/> Standing more than _____ minutes | | |
| <input type="checkbox"/> Walking more than _____ minutes or a distance of _____ | | |
| <input type="checkbox"/> Other: | | |

Do you have any other medical considerations/directives that you would like us to be aware of (such as DNR, DNI)?

Is there any additional information you want to share? (For example, cultural or spiritual beliefs that affect care.)

Form completed by: _____ **Relationship to client:** _____