HELEN HAYES
HOSPITAL
Helen Hayes Hospital, Route 9W, West Haverstraw, NY 10993

Outpatient Health Questionnaire

Primary complaint or reason for coming to therapy services: _____

_____

Briefly describe your symptoms: _____

_____

Have you had therapy (either outpatient or home) previously for the current diagnosis? ❑ Yes ❑ No

If yes, when and for how long? _____

_____

Have you been hospitalized within the past 6 months? ❑ Yes ❑ No

If yes, when and what for? _____

_____

Have you had any falls within the past 6 months? ❑ Yes ❑ No

If yes, when? _____

_____

Clinical
Depts
PT
9/2020

Have you had or do you have any of the following health related issues? Check all that apply.

Past	Present		Past	Present	
❑	❑	High Blood Pressure	❑	❑	Hepatitis
❑	❑	Heart Attack	❑	❑	HIV/AIDS
❑	❑	Pacemaker	❑	❑	Epilepsy/Seizures
❑	❑	Angina	❑	❑	Parkinson's Disease
❑	❑	Stroke	❑	❑	Guillane Barre
❑	❑	Diabetes	❑	❑	Systemic Disease
❑	❑	High Cholesterol			Lupus/Lyme/Fibromyalgia
❑	❑	Arthritis: Osteo or Rheumatoid	❑	❑	Pregnancy
❑	❑	Osteoporosis/Osteopenia	❑	❑	Tobacco: packs/day:
❑	❑	Cancer: Type: _____	❑	❑	Drug or alcohol dependence
❑	❑	Asthma	❑	❑	Other: _____
❑	❑	COPD/Emphysema	❑	❑	Allergies:
❑	❑	Depression/Anxiety			_____
❑	❑	Surgeries:			_____

Type: _____ Date: _____
Type: _____ Date: _____
Type: _____ Date: _____

Continued on back . . . .

Patient's Name: _____

List medications that you are presently taking and the dosage and frequency:

_____

_____

_____

Please list any medical equipment that you currently own (i.e. rolling walker, hospital bed, shower chair, etc.)

_____

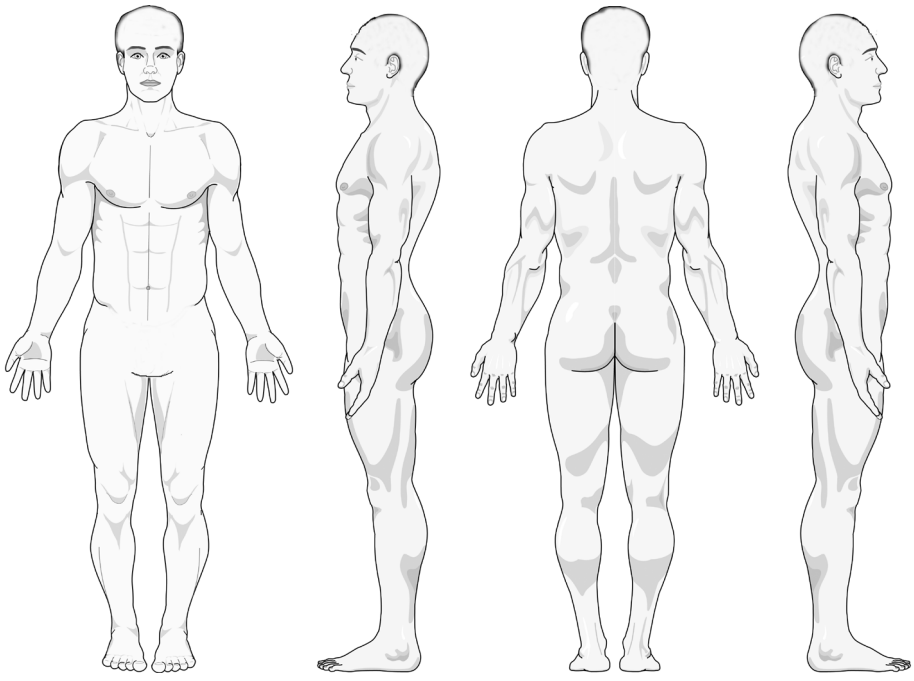
_____

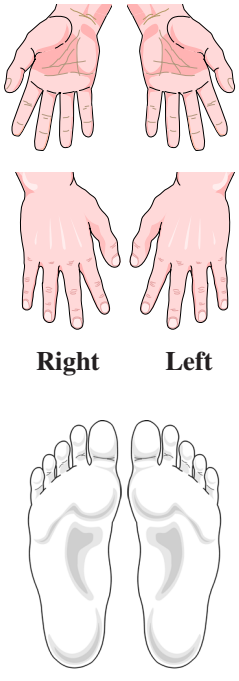
Occupation:

❑ Working full time ❑ Disabled since (date): _____ ❑ Retired since (year): _____

❑ Working part time ❑ Unemployed

Indicate below where you have your pain or symptoms.





Circle the number that indicates the intensity of your pain at its lowest (0 = no pain; 10 = the worst)

0 1 2 3 4 5 6 7 8 9 10

Circle the number that indicates the intensity of your pain at its highest (0 = no pain; 10 = the worst)

0 1 2 3 4 5 6 7 8 9 10

Describe your symptoms (check all that apply):

❑ sharp ❑ ache ❑ throbbing ❑ pinching ❑ shooting ❑ burning ❑ radiating

❑ tingling ❑ tender ❑ dull ❑ numb ❑ stabbing ❑ tight ❑ crushing

How often do you experience your symptoms?

❑ constantly (76-100% of the day) ❑ occasionally (26-50% of the day)

❑ frequently (51-75% of the day) ❑ intermittently (0-25% of the day)

How are your symptoms changing? ❑ getting better ❑ getting worse ❑ not changing