

# NEURO INSTITUTE, INC.

## HEALTH HISTORY FORM

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please check the appropriate box or write your answers to the following questions:

**NEUROLOGICAL CONDITIONS:** Please check all that apply

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Spinal Cord Injury       | <input type="checkbox"/> Brain Injury          | <input type="checkbox"/> Cerebral Palsy        |
| <input type="checkbox"/> Cervical Level C__ - C__ | <input type="checkbox"/> Open Injury           | <input type="checkbox"/> Multiple Sclerosis    |
| <input type="checkbox"/> Thoracic Level T__ - T__ | <input type="checkbox"/> Closed Injury         | <input type="checkbox"/> Stroke/CVA            |
| <input type="checkbox"/> Lumbar Level L__ - L__   | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Polio                    | <input type="checkbox"/> Seizure Disorder      | <input type="checkbox"/> Partial               |
| <input type="checkbox"/> Other: _____             |  | <input type="checkbox"/> Full                  |

**SYMPTOMS/MANIFESTATIONS:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Paralysis or severe weakness:                                     | <input type="checkbox"/> Difficulty Walking  | <input type="checkbox"/> Loss of balance           |
| <input type="checkbox"/> Lower extremities   | <input type="checkbox"/> Generalized weakness  | <input type="checkbox"/> Muscle wasting            |
| <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> Weakness: <input type="checkbox"/> Arms <input type="checkbox"/> Legs | <input type="checkbox"/> Speech impairment         |
| <input type="checkbox"/> Upper Extremities   | <input type="checkbox"/> Back Pain   | <input type="checkbox"/> Impaired memory           |
| <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> Loss of control bladder/bowel   | <input type="checkbox"/> Vision impairment         |
| <input type="checkbox"/> Limited range of motion of:                                       | <input type="checkbox"/> Impaired cognitive functions  | <input type="checkbox"/> Weakness of arms          |
| <input type="checkbox"/> Neck <input type="checkbox"/> Elbow                               | <input type="checkbox"/> Muscle Spasms   | <input type="checkbox"/> Hearing impairment        |
| <input type="checkbox"/> Back <input type="checkbox"/> Wrist/Hand                          | <input type="checkbox"/> Numbness of: _____  | <input type="checkbox"/> Impaired swallowing       |
| <input type="checkbox"/> Shoulders <input type="checkbox"/> Hips                           | <input type="checkbox"/> Fear of falling   | <input type="checkbox"/> Dizziness                 |
| <input type="checkbox"/> Ankle <input type="checkbox"/> Knees                              | <input type="checkbox"/> Peripheral Neuropathy   | <input type="checkbox"/> History of Pressure Sores |

**GENERAL CONDITIONS:** Please check all that apply

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Alcoholism          |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Psychiatric care    | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> Liver disease       |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Thyroid problems    | <input type="checkbox"/> Bleeding disorders  |
| <input type="checkbox"/> Gout                | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Heart Disease       |
| <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart Attack        |
| <input type="checkbox"/> Pregnant            | <input type="checkbox"/> Hernia              | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Pulmonary Disease   | <input type="checkbox"/> Amputation          |

**ALLERGIES:**

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Tempe, AZ 85284  
(480) 735-0124

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**HEALTH HISTORY FORM**

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Date of Birth: \_\_\_\_\_

**MEDICATIONS (including vitamins):**

Name	Dose	# times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**SURGERIES:** Please list all past surgeries you have had:

Surgery	Date	Complications(describe)

**SOCIAL HISTORY:**

Marital Status:  Single  Married  Divorced  Widowed

Do you smoke?  Yes  No If yes, how many packs per day? \_\_\_\_\_

Did you quit smoking?  Never smoked  Yes  No If yes, when? \_\_\_\_\_

Do you use other tobacco products?  Yes  No If yes, what? \_\_\_\_\_

How many alcoholic beverages, on average, do you drink each week?

None  1-2  3-4  5-8  9-12  over 12

**PERSONAL MEDICAL HISTORY:** Please list any other current or past medical conditions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any falls recently? How many in the past week? Past month? Describe the circumstances:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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What type of equipment do you have at home?

€ Wheelchair    € Walker    € Quad Cane    € Single Point Cane    € Tub Bench

€ Reachers    € Raised Toilet/Seat    € Bracing (i.e Ankle/foot brace)

€ Splints    € Other \_\_\_\_\_

What type of home do you have?

€ Single story    € Multiple Level    € # of Steps/Enter-Exit \_\_\_\_\_

€ Railing Left or Right    € Tile Flooring    € Carpeting    € Other \_\_\_\_\_

€ Wheelchair accessible doorways    € Tub/Shower combination    € Step-in Shower

Please describe in detail how you manage dressing, bathing, and toileting and meal preparation?

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Who assists you in activities such as dressing, bathing, toileting, etc.?

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On a scale of 1-5, rate the degree of assistance that you require for the following activities:  
(1 = complete Dependence & 5 = complete Independence)

Dressing \_\_\_\_\_ Bathing \_\_\_\_\_ Toileting \_\_\_\_\_ Feeding \_\_\_\_\_ Meal Preparation \_\_\_\_\_

House Keeping \_\_\_\_\_ Transportation \_\_\_\_\_ Managing Finances \_\_\_\_\_

Medication Management \_\_\_\_\_ Scheduling Appointments \_\_\_\_\_

Understanding Complex/New Information \_\_\_\_\_ Making your own needs known/understood \_\_\_\_\_

Understanding Written Information \_\_\_\_\_

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Do any of these activities require help/assistance for the following transfers? Please check all that apply:

- Getting in/out of bed     Moving around in the bed     Getting on/off the toilet  
 Getting in/out shower     Getting into the car     Standing up

Do you have any difficulty eating or swallowing? Do you have any difficulty with liquids or solids? Do you cough when eating or have had pneumonia in the past six (6) months? Please describe in detail.

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Have you had any of the following therapeutic intervention?

- Botox    Splinting    Serial Casting    Wheelchair/Seating Evaluation  
 Neuropsychological Evaluation    Pulmonology work-up    Modified Barium Swallow  
 Ear Nose & Throat for vocal cord problems

In the past, have you been seen for:

- Physical Therapy    Occupational Therapy    Speech Therapy

Please describe in detail, any previous therapy that you had in the past two (2) years, including dates, places and benefits you feel you achieved:

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**TREATMENT GOALS:** Please describe what you wish to accomplish with your treatment here.

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**PHYSICIAN INFORMATION**

Name of Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date last seen: \_\_\_\_\_ Did this doctor refer you to us? Y / N

Name of other Physician involved in your care: \_\_\_\_\_  
Specialty: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
**Patient or Representative's Signature**

\_\_\_\_\_  
**Name Printed**

\_\_\_\_\_  
**Date**