UnityPoint Health
Trinity

Patient Questionnaire

To ensure that you receive a complete and thorough therapy evaluation, it is important that you provide current health history information below. If you do not understand a question, or need assistance filling out these forms, please ask a staff member.

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

☐ Arthritis
☐ Osteoporosis
☐ Lung problems
☐ Asthma
☐ Heart problems
☐ High blood pressure
☐ Stroke
☐ Pacemaker/another implanted device
☐ Other:_____

☐ Diabetes
☐ Kidney/bladder problems
☐ Incontinence
☐ Stomach/GI problems
☐ Depression
☐ Anxiety

☐ Cancer _____
☐ Parkinson's
☐ Multiple Sclerosis
☐ Seizure disorder/Epilepsy
☐ Changes in memory/cognition
☐ Speech difficulties
☐ Other mental health diagnoses/concerns
☐ Chemical Dependence

Have you RECENTLY noted any of the following that are new or unexplained (check all that apply)?

☐ Changes in bowel or bladder function
☐ Nausea/vomiting
☐ Dizziness/lightheadedness
☐ Difficulty swallowing

☐ Weakness/fatigue
☐ Shortness of breath
☐ Severe headaches
☐ Changes in appetite

☐ Fever/chills/sweats
☐ Pain at night/sleep disturbance
☐ Unexpected weight loss/gain
☐ Numbness and tingling sensations

Please list any surgeries or recent hospitalizations including dates:

_____

_____

_____

_____

List any medications you are currently taking (You may also attach a printed list):_____

_____

_____

_____

_____

_____

Allergies (latex, medications):_____

_____

_____

_____

ANNUAL THERAPY HEALTH HISTORY

UP MR 060
(7/2026)

Patient Label

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Trinity

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Do you have impaired vision (that cannot be corrected with lenses), and/or impaired hearing? ☐ Yes ☐ No
If yes, please specify:_____

Have you had 2 or more falls in the past year? ☐ Yes ☐ No

Do you have concerns about balance or falling? ☐ Yes ☐ No
If yes, please specify:_____

Do you use a device, such as a cane or walker, to help you walk? ☐ Yes ☐ No
If yes, please specify: _____

Do you use tobacco or nicotine containing products? ☐ Yes ☐ No
If YES, please specify: _____

Are you currently pregnant or think you might be pregnant? ☐ Yes ☐ No

Are you currently breast feeding? ☐ Yes ☐ No

Do you have any history of physical or emotional abuse that you would like us to be aware of? ☐ Yes ☐ No

Are you currently in a relationship in which you feel unsafe or threatened? ☐ Yes ☐ No

At the present time, would you say that your health is (Please check answer)

☐ **Excellent** ☐ **Fair**
☐ **Very Good** ☐ **Poor**

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

Patient Name	Date/Time
Patient or Legally Authorized Representative Signature	Relationship to patient (if other than patient)

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