Therapy

UnityPoint Health
Des Moines

Date_____ Legal Name _____ Date of Birth_____ EMR_____
(First) (Middle) (Last)

Preferred Name_____ Pronouns ☐ She/Her ☐ He/Him ☐ They/Their ☐ Other_____

Gender Identity: ☐ Female ☐ Male ☐ Transgender woman ☐ Transgender male ☐ Other Identity: _____

Gender Listed on Insurance _____

Have you received any home health services or other outpatient therapy services this year? ☐ Yes ☐ No

Medical History

Are you pregnant? ☐ Yes ☐ No If yes, how many weeks? _____

Have you experienced pregnancy related pain? ☐ Yes ☐ No If yes, explain_____

Special Tests done: ☐ X-Ray ☐ Bone Scan ☐ CT Scan ☐ MRI ☐ Other_____

List any allergies (i.e. latex, adhesives) _____

Have you ever been told you have or had the following (check Yes or No)

Cancer	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Osteoarthritis	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Hepatitis (A, B, C)	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fibromyalgia	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Lung Disease (COPD)	☐ Yes ☐ No	Angina/Chest Pain	☐ Yes ☐ No	Other: _____	☐ Yes ☐ No
Pelvic Health Dx	☐ Yes ☐ No				

List prior surgery (ies)_____

Are you currently taking any medications, herbals, vitamins, supplements? ☐ Yes ☐ No

If yes, please list medication name, dose, etc: _____

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 ☐ ☐ Other _____

Circle pain now: 0 1 2 3 4 5 6 7 8 9 10

How often does it hurt? _____

What makes your symptoms worse? _____

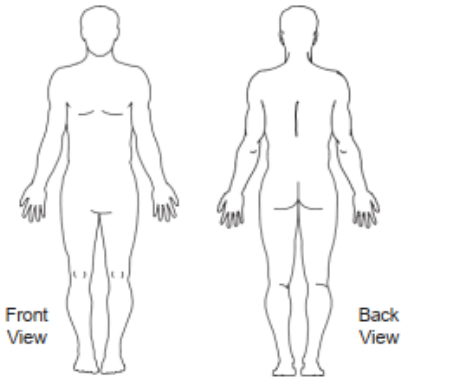
_____

What makes your symptoms better?_____

_____

What are your therapy goals? _____

Please shade your area(s) of greatest discomfort



Permanent Part of Medical Record

Patient Label

OUTPATIENT QUESTIONNAIRE