Oroville Hospital

Golden Valley Outpatient Rehabilitation
Patient Health Questionnaire

Patient Name:

What condition brings you here today?

When did your injury or condition first occur?

Were you hospitalized for this condition?
Yes ☐ No ☐
When: to
Where:

Procedures you have had done for this condition:
☐ MRI
☐ CT scan
☐ X-ray
☐ EMG
☐ EKG
☐ EEG
☐ Other
☐ Injections/blocks
☐ Swallow study x-ray
☐ Surgery(date)

Has your Doctor given you any precautions?

Have you been treated for this before?
Yes ☐ No ☐
Dates:
Where/By whom?:

Are you seeing any other specialists for your condition?

Do you feel that you fully understand your diagnosis?
Yes ☐ No ☐

Are you in pain right now? *(if yes, please also use chart attached at the end of this packet)*
Yes ☐ No ☐
Where:

Please rate your pain from 1-10 *(1 being the least, 10 the most imaginable)*
1
How do you normally manage this type of pain?

What aggravates your pain?

Living/Social Situation

Who do you live with?

Do you have family or close friends nearby?

Do you have a caregiver?
Yes ☐ No ☐
Who:

How many hours per day/week?

What do you need help with?

Is there someone to assist you with your home exercises?:
Yes ☐ No ☐

Do you foresee any problems with attending therapy sessions?

Your favorite activities/hobbies *(now and before your change in condition)*

Prior to your injury/illness what did you do that you are no longer able to do?

Highest Level of Education Achieved:

Health History:
Check any that you have had or currently have:

☐Rheumatic Fever
☐Heart Disease
☐Rheumatoid Arthritis
☐Any bone or joint disease
☐Bursitis, sciatica, lumbago
☐Polio or Meningitis
☐Kidney problems
☐Seizure disorder
☐Migraine headaches
☐Tuberculosis
☐Diabetes
☐Cancer
☐Incontinence
☐Allergies (please list)

☐High blood pressure
☐Low blood pressure
☐Eczema or Hives
☐Asthma
☐Broken bones
☐Dislocations
☐Concussion
☐Head injury
☐Pacemaker
☐Defibrillator
☐Fainting or dizziness
☐Double vision
☐Artificial joints

Are you or could you be pregnant? Yes ☐ No

List all surgeries and dates:

Current Dwelling:
House One Story
Other:

(mark any that apply)

Equipment Used:

- ☐ Single point cane
- ☐ Quad Cane
- ☐ Front wheeled walker
- ☐ 4 wheeled walker
- ☐ Bedside commode
- ☐ Shower chair/tub transfer bench
- ☐ Hospital Bed

Do you have:

- ☐ Stairs to climb
- ☐ Railing
- ☐ Ramp
- ☐ Uneven Terrain
- ☐ Glasses
- ☐ Hearing Aid
- ☐ Assistive devices for bathing/dressing
- ☐ Splint for Hand/Arm
- ☐ Brace for Leg

Have you fallen since you were diagnosed?

Yes ☐ No ☐

How many times?:

Why?

What are your goals for therapy? *(mark any that apply)*

- ☐ Reduce pain
- ☐ Walk unassisted
- ☐ Improve balance
- ☐ Improve flexibility
- ☐ Prevent surgery
- ☐ Increase endurance
- ☐ Increase strength
- ☐ Improve posture
- ☐ Increase coordination
- ☐ Increase use of my hand
- ☐ Improve my ability to dress myself
- ☐ Improve my ability to speak and understand
- ☐ To be able to go use the bathroom independently
- ☐ To be able to manage my own finances
- ☐ Improve my ability to swallow
- ☐ Improve my ability to return to work
- ☐ To increase my ability to go out in the community
- ☐ Be able to cook a meal
- ☐ To improve my memory or learn to compensate

Other:

Do you currently: *(mark any that apply)*

- ☐ Have difficulty sleeping
- ☐ Have issues with your living situation
- ☐ Get bothered by feeling down, hopeless, anxious
- ☐ Experience lack of energy for daily tasks
- ☐ Have questions about services and how to obtain them
- ☐ Have relationship problems

Would you like to be referred to a social worker who can help (no cost and CONFIDENTIAL)

Yes ☐ No ☐

Please READ CAREFULLY and sign below:

- Your regular participation in therapy and follow through with your home program is essential to your recovery! It is important for you to keep scheduled appointments to achieve the best possible outcome. Should you need to cancel an appointment, please call our front desk @ **530-712-2196** as soon as possible (we appreciate at least 24 hours notice).

- We know life is busy and mistakes happen! We make an effort to work with every patient to ensure they have a successful outcome from therapy. Please speak to your therapist if your diagnosis makes it difficult for you to remember your appointments. You are the most important part of your recovery! In order to ensure the smooth operation of our clinic and the best outcomes for you:

    - **If you miss an appointment without giving us prior notification, do not have any other appointments on the books, and do not call to reschedule within the following 7 days, we will assume you no longer want to have therapy with us and will dismiss you from services.**

    - **If you miss a total of 3 appointments or 2 in a row without giving us prior notification, we assume that now is not a good time for you to devote yourself to doing therapy and will dismiss you from services.**

- *If you are dismissed from services as above and find you are ready to resume again at a later date, we would be happy to have you return! Just obtain a new prescription from your doctor and contact us to schedule your evaluation.*

We look forward to partnering with you in your rehabilitation process and appreciate you for choosing Golden Valley Outpatient Rehabilitation!

I acknowledge that I understand the policies and have completed this form to the best of my knowledge.

Patient's Signature: **Date:**

SUBMIT