Medical History and Social Service Questionnaire

Patient Name: _____ Social Security Number: _____
Occupation: _____ Reason for Referral: _____
Preferred Personal Pronoun (optional)_____
Emergency Contact Name/Relation: _____ Phone Number: _____
Was Surgery Performed Y or N Type of Surgery _____ Date of Surgery _____/_____/_____

Pain Level (0-10) 0 = No Pain 10 = Extreme Pain Current _____ At Rest _____ With Activity _____
Medications – Please circle if you are taking any of the following.
Anti Inflammatory Muscle Relaxers Pain Medication Other Medications (please provide list or list on back)

Rehabilitation Services - Please circle if you have had any of the following Medical/Rehabilitation Services for **THIS** Injury
General Practitioner Orthopedist Neurologist Podiatrist
Emergency Room Chriopractor Physical Therapy
MRI X-Ray CT Scan Arthrogram EMG/NCV Results: _____

Past / Present Conditions – Please circle ALL conditions you currently have or have had.

Respiratory Problems	Shortness of Breath	Chest Pain/Heart Disease	Pacemaker
Heart Attack	Heart Surgery	Irregular Heartbeat	Stroke / TIA
Headaches	Parkinson's Disease	Multiple Sclerosis	Epilepsy / Seizures
Diabetes IDDM / NIDDM	Cancer / Chemotherapy	Type of Cancer: _____	
High Blood Pressure	Hearing Difficulty	Vision Difficulty	Thyroid Conditions
Nausea	Dizziness or Fainting	Numbness or Tingling	Muscle Weakness
Weight Loss / Energy Loss	Sleeping Difficulty	Depression / Anxiety	Psychological Conditions
Bowel or Bladder Problems	Arthritis Osteo / Rheumatoid	Osteoporosis	Falls in past 12 months
Pins / Metal Implants	Infectious Diseases	Allergies	Smoking
Pregnant / Nursing			

Past Two Surgeries:
Type _____ Date (Mo./Yr.)_____
Type _____ Date (Mo./Yr.)_____
Other Relevant Conditions:_____

PHQ

1. During the past month, have you often been bothered by feeling down, depressed or hopeless? Yes or No
2. During the past month, have you often been bothered by little interest or pleasure in doing things? Yes or No

EASI: Within the last 12 months:

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals? Yes or No
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with? Yes or No
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened? Yes or No
4. Has anyone tried to force you to sign papers or to use your money against your will? Yes or No
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? Yes or No

As a component of our participation in the Medicare program, we have partnered with a professional who can provide social services to our clients and can assist them in exploring community resources available to obtain the basic necessities for living. Please circle if you have difficulty with any of the following **as a result of your current medical condition** ?

Obtaining food or medicine Paying Rent / Utilities Transportation
Safety Issues at home Financial Stress Other: _____

Do you feel that you require any assistance from a social worker while enrolled in therapy? Y or N

Patient / Guardian Signature _____ **Date** _____/_____/_____
Therapist Signature (reviewed form with pt.) _____ Date _____/_____/_____
Date social worker contacted _____/_____/_____ Therapists Initials _____