KVH
Kittitas Valley Healthcare
Speech Therapy
Your Home for Health

Occupational Therapy Patient - Initial Health Questionnaire

Patient Name _____ DOB ___/___/___ Age _____ Today's Date ___/___/___

Referring Physician _____ Other/Primary Physician _____

1. For which problem(s) are we seeing you today? _____

_____

2. Please describe your symptoms: _____

_____

3. When did the symptoms start? _____

4. Are your symptoms constant or intermittent? ☐ constant (24 hours/day) ☐ intermittent (come and go)

5. How do your symptoms vary over a 24-hour period?

Morning _____ Noon _____

Evening _____ Night _____

6. Please select the rating that best describes your symptoms:

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
No symptoms		Mild symptoms, annoying		Nagging symptoms, uncomfortable, troublesome		Miserable, distressing		Intense, dreadful, horrible		Worst symptoms possible, unbearable

7. What activities increase your symptoms? _____

8. What activities decrease your symptoms? _____

9. Do you have difficulties with any of these, because of your problem? (Check all that apply)

☐ Walking	☐ Throwing	☐ Preparing food	☐ Dressing
☐ Getting out of bed	☐ Getting in/out of car	☐ Cutting food	☐ Showering/bathing
☐ Squatting	☐ Driving	☐ Housekeeping	☐ Toileting/hygiene
☐ Reaching	☐ Carrying objects	☐ Childcare	☐ Writing

10. Are you currently being treated for other diagnosed medical problems? ☐ Yes ☐ No

If yes, please explain: _____

11. Have you had previous treatment for the same problem/symptoms? ☐ Yes ☐ No

If yes, please describe: _____

12. Have you had diagnostic testing (x-ray, MRI, CT) for your current problem? ☐ Yes ☐ No

If yes, please describe: _____

13. Please list previous surgeries, fractures, or serious injuries, with approximate dates: _____

14. List any metal implants (pins/plates, pacemaker) you have, if any: _____

Please complete both sides of form.

KVH Occupational Therapy | Initial Health Questionnaire, Cont.

15. Have you ever been in a car accident? ☐ Yes ☐ No

If yes, list date(s) and injuries: _____

16. Is the problem you are being treated for involved in litigation (lawsuit)? ☐ Yes ☐ No

17. What is your goal for your therapy treatment? _____

_____

18. Occupation: 19. You live with: ☐ self ☐ spouse ☐ family ☐ other

20. Please list all current medications, including over-the-counter and supplements. Attach another sheet if necessary.

_____

_____

21. Please list any allergies to foods, latex, adhesives, or medications: _____

_____

22. Have you been diagnosed with any of the following conditions?

	Yes	No
Recent infection	☐	☐
High blood pressure	☐	☐
Diabetes (with or without neuropathy)	☐	☐
Heart problems	☐	☐
Stroke/TIA	☐	☐
Cancer	☐	☐
Bowel or bladder problems	☐	☐
Kidney problems	☐	☐
Thyroid problems	☐	☐
Breathing difficulties	☐	☐
Seizures	☐	☐

	Yes	No
Frequent falls	☐	☐
Osteoporosis	☐	☐
Arthritis (e.g. RA/rheumatoid, osteoarthritis)	☐	☐
Depression or anxiety	☐	☐
Dizziness or vertigo	☐	☐
Multiple Sclerosis	☐	☐
Hepatitis/Tuberculosis/MRSA (circle)	☐	☐
Headaches	☐	☐
Are you pregnant?	☐	☐
Other (describe):	☐	

23. Is there anything else you'd like to tell us about your problem? _____

_____

_____

_____

THIS SECTION COMPLETED BY CLINIC STAFF

KVH Occupational Therapist Reviewing Questionnaire *Date*