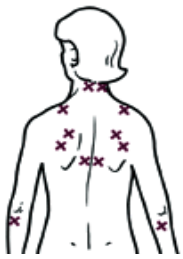

HILTON HEAD OCCUPATIONAL THERAPY
PATIENT HISTORY SELF REPORT

Name: _____ Date: _____

What is the reason you have come to OT? _____

_____

When did you first see your physician for this problem? _____

Please indicate which you have had for your condition: ☐ PT ☐ OT ☐ X-ray ☐ MRI ☐ Injection ☐ Other

Dates of hospitalization for this condition: _____

Describe your condition as you understand it. _____

_____

What makes your problem worse? _____

What makes it better? _____

If you have pain, what increases your pain? _____

What words describe the way your pain feels? _____

Does you pain increase or decrease at certain times of the day? ☐ Yes ☐ No

If yes, please explain: _____

Does your pain disturb your sleep? ☐ Yes ☐ No How long can you sleep? _____

Please rate your pain on the following scale:

Now ☐ 0 1 2 3 4 5 6 7 8 9 10

No pain Severe Pain **Need to go to the ER**

At Best  ☐ 0 1 2 3 4 5 6 7 8 9 10

No pain

At Worst  ☐ 0 1 2 3 4 5 6 7 8 9 10

No pain

Do you engage in regular exercise? ☐ Yes ☐ No How often? _____ times per week.

What are (3) of your favorite recreational activities? **MOST** favorite (1) to **LEAST** (3) favorite:

Most favorite 1) _____

2) _____

3) _____

Please indicate the activities above that you STILL CAN DO *without pain*: 1) ___ 2) ___ 3) ___

Please list the MOST IMPORTANT activity that you CANNOT DO but WANT to do: _____.

What is/was your occupation? _____

If retired, what is your PRIMARY avocation: _____

Do you spend a lot of time sitting in a usual day? ☐ Yes ☐ No

How long can you sit at one time? _____ Minutes _____ Hours

How long can you stand at one time? _____ Minutes _____ Hours

How long can you walk at one time? _____ Minutes _____ Hours

Please list any medications you are taking (yes! This includes VITAMINS/HERBS!):

1) _____ 3) _____ 5) _____

2) _____ 4) _____ 6) _____

Do you have any allergies to medications or latex? ☐ Yes ☐ No

If yes, please list what you are allergic to: _____

℞ Please indicate if any of these conditions currently apply to you:

☐ Diabetes	☐ HIV/AIDS	☐ Neurological Problems	☐ Kidney Disease
☐ Pacemaker	☐ Lung Disease	☐ High Blood Pressure	☐ Heart Murmur
☐ Cancer	☐ Liver Disease	☐ Circulatory Problems	☐ Metal Implants
☐ Dizziness	☐ Arthritis	☐ Epilepsy/Seizures	☐ Migraines
☐ Osteoporosis	☐ Heart Disease	☐ Head Injury	☐ Other _____

Have you had any broken bones or torn muscles? ☐ Yes ☐ No

If yes, where? _____

_____

Have you had any previous surgeries? ☐ Yes ☐ No

If yes, what surgeries and when? _____

_____

Please check the correct answer:

I can roll over in bed.....	☐ alone	☐ with help	☐ unable	☐ w/pain
I can bathe	☐ alone	☐ with help	☐ unable	☐ w/pain
I can get in and out of the bath/shower.	☐ alone	☐ with help	☐ unable	☐ w/pain
I can get in and out of the car	☐ alone	☐ with help	☐ unable	☐ w/pain
I can drive	☐ alone	☐ with help	☐ unable	☐ w/pain
I can do grocery shopping	☐ alone	☐ with help	☐ unable	☐ w/pain
I can walk in the community	☐ alone	☐ with help	☐ unable	☐ w/pain
I can stoop/squat	☐ alone	☐ with help	☐ unable	☐ w/pain
I can do laundry	☐ alone	☐ with help	☐ unable	☐ w/pain
I can clean the house	☐ alone	☐ with help	☐ unable	☐ w/pain
I can access all areas of my house	☐ alone	☐ with help	☐ unable	☐ w/pain
I can reach	☐ alone	☐ with help	☐ unable	☐ w/pain
I can dress	☐ alone	☐ with help	☐ unable	☐ w/pain
I can groom	☐ alone	☐ with help	☐ unable	☐ w/pain
I can cook	☐ alone	☐ with help	☐ unable	☐ w/pain
I can eat	☐ alone	☐ with help	☐ unable	☐ w/pain
I can use the phone	☐ alone	☐ with help	☐ unable	☐ w/pain
I can write	☐ alone	☐ with help	☐ unable	☐ w/pain

I have neither tripped nor have I fallen in the past year	☐ Yes	☐ No
I have tripped but not fallen in the past year	☐ Yes	☐ No
I have had a fall in the past year	☐ Yes	☐ No
I have fallen two or more times within the past year	☐ Yes	☐ No

I have fallen _____ times within the past year

Please finish this statement: "I would know I was getting better if I could _____

_____."

_____ _____ _____

Patient Signature Date Reviewing O.T.

FAX to (843) 757-9294