St. Luke's Rehabilitation Institute
INLAND NORTHWEST HEALTH SERVICES

Health Survey

www.st-lukes.org

NAME: _____DATE: ___/___/_____ Age**: _____** Sex ☐ M ☐ F

Name of Legal Guardian if patient is minor _____

Primary Phone: (____) _____ ☐ Mobile ☐ Home Alternative Phone: (____) _____

Emergency Contact: _____ (____) _____ _____
Name Phone # Relationship

Occupation: _____ Highest Level of education completed _____

LANGUAGE_____ ETHNICITY: (Mark box below)

☐Black/African American ☐Asian/Pacific American ☐White American
☐Native American/Alaskan Native ☐Latina/Latino/Hispanic American ☐Other_____

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN:_____
HAVE YOU SOUGHT THERAPY ELSEWHERE WITHIN LAST 3 MONTHS?
☐NO ☐YES/LOCATION_____.

ALLERGIES: (Drug, Seasonal, Latex, or Food related**)** ☐NO ☐YES_____
HANDEDNESS: ☐Right ☐Left **HEIGHT_____ WEIGHT_____**

REASON FOR THERAPY_____

WHAT ARE YOUR THERAPY GOALS?_____

TRAVEL RISK SCREENING: Have you or someone you are in contact with traveled out of the country in the last 21 days? ☐NO ☐YES/LOCATION_____.
If YES, Are you or the person you are in contact with experiencing any of the following symptoms:

☐Bleeding ☐Diarrhea ☐Vomiting/Stomach Pain
☐Joint/Muscle pain ☐Headache ☐Rash
☐Respiratory Symptoms ☐Temp over 100.4F ☐Conjunctivitis/Pink eye

_____ Staff only: ☐Referred to PCP_____

MEDICAL HISTORY: (Mark a box if you have had any of these conditions and explain below)

☐ Anemia ☐ Hepatitis ☐Injury Spinal/Neck ☐ Pulmonary
☐ Anxiety/Depression ☐ HIV / AIDS ☐ Kidney Disease Disease/COPD
☐ Arthritis ☐ Hypertension (High ☐ Mental illness ☐ Seizures
☐ Asthma Blood Pressure) ☐ Nerve/Muscle ☐ Stroke
☐ Cancer ☐Injury Wrist/Hand Disease ☐ Substance Abuse
☐ Diabetes Mellitus ☐Injury Foot/Ankle ☐ Osteoporosis ☐ Thyroid Disease
☐ Eye disease ☐Injury Head ☐Pacemaker/☐Defibrill ☐ Tuberculosis
☐ Hearing loss ☐Injury Hip/Leg/Knee ator ☐ Vision Loss
☐ Heart Disease ☐Injury Shoulder
☐ Other (Please List) _____ Explain: _____

SURGICAL HISTORY:

☐Breast Surgery ☐ Eye Surgery ☐ Ear Surgery ☐ Fracture Surgery ☐Brain Surgery
☐ Heart Surgery ☐ Hysterectomy ☐ Prostate Surgery ☐ Small intestine
☐ Hernia Repair ☐ Joint Replacement Surgery
☐ Other (Please List) _____ Explain: _____

ADDRESSOGRAPH

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FAMILY HISTORY: (Please mark which relative & listed condition)

Arthritis_____ Cancer_____ Heart Problems_____
Anxiety/Depression_____ Diabetes_____ Other _____

SOCIAL HISTORY:

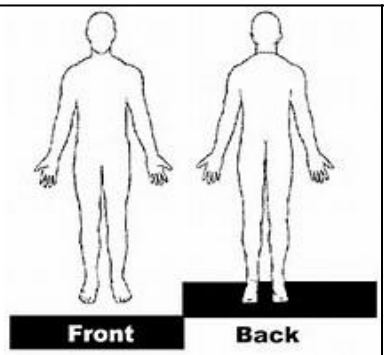
☐Currently Smokes ☐Has smoked in the past ☐Smokes Every Day ☐Never Smoked ☐Passive Smoker
Alcohol use: ☐Yes ☐No Times per week_____ Drug Use: ☐Yes ☐No Times per week_____
Exercise**:** ☐ 1 time per day ☐ Few times per week ☐ Few times per month ☐ Never
Current Quality of Life/Health Status: ☐Excellent ☐Good ☐Fair ☐Poor

Do you have ☐transportation, ☐housing, or ☐financial concerns? ☐NO ☐YES_____

Are you concerned about your safety or violence at home? ☐NO ☐YES_____

REVIEW OF SYSTEMS: (Please check all CURRENT symptoms)

General: ☐Chills ☐Fatigue ☐Fevers
Endocrine: ☐Pregnant or planning a pregnancy ☐Unintentional Weight Loss
ENT: ☐Hearing loss ☐Ear ringing ☐Ear pain ☐Congestion ☐Sore Throat
Eyes: ☐Blurred Vision ☐Eye pain ☐Double vision ☐Loss of vision ☐Light sensitivity
Cardio: ☐Chest pain ☐Palpitations ☐Leg/foot swelling
Urinary: ☐Blood in Urine ☐Urinary incontinence ☐Urinary retention
Neuro: ☐Dizziness ☐Tremors ☐Numbness ☐Seizures ☐Loss of balance
Psych: ☐Depression ☐Alcohol/Drug dependence ☐Anxiety
Gastrointestinal: ☐Heartburn ☐Nausea/Vomiting ☐Abdominal Pain ☐Blood in stool
Hematologic / Lymphatic: ☐Bleeding Problems ☐Blood clots ☐Blood transfusions ☐Bruising



MARK THE AREAS OF THE BODY WHERE YOU FEEL PAIN

Choose the number from pain scale that best describes your pain:
No pain+0 1 2 3 4 5 6 7 8 9 10+Maximum Pain

RIGHT NOW_____.
BEST day in past 30 days_____.
WORST day in past 30 days _____.

MEDICATION LIST: (Please provide your complete list of Current Medications)

Medication/Injection	Dosage	Prescribing Physician	Phone Number
_____	_____	_____	(____) _____
_____	_____	_____	(____) _____
_____	_____	_____	(____) _____
_____	_____	_____	(____) _____
_____	_____	_____	(____) _____

We have provided the following documents for your review:*(Copies are available upon your request)*
☐Patient Rights and Responsibilities ☐Consent to Treat

_____ _____ __/__/___
Signature of Patient or Legal Guardian Relationship to patient Date

ADDRESSOGRAPH