SAI Outpatient History Questionnaire

Name:_____ Preferred Pronouns: He She Ze They

Please describe your current condition_____

Date when current condition began: _____ Occupation:_____

What are your goals for therapy?_____

Have you fallen in the past year?	YES NO
Do you feel unsteady when walking or standing?	YES NO
Do you worry about falling?	YES NO
Would you like to speak with someone regarding suicide?	YES NO
Would you like to speak with someone regarding current abuse or neglect?	YES NO
Have you been diagnosed with Candida auris (C.auris)	YES NO

Home Environment: Single level Multilevel Stairs: **Yes NO** Ramp: **YES NO**

Do you live alone? **YES NO** Do you have a caregiver? **YES NO**

Do you use any of the following? Wheelchair Walker/rollator Crutches Cane

Please list your current medications:

_____

_____

Have you recently had any of the following?: X-ray MRI CT Scan Myelogram EMG/NCS Swallow study

Results:_____

Are you allergic to latex?: **YES NO** Medication Allergies: **YES NO** please list below:

_____

Please indicate **YES**: this disease **is** present in medical history or **NO**: the disease **is NOT** present in medical history:

Arthritis (rheumatoid and/or arthritis) Also gout or autoimmune disorders causing arthritis, e.g. Sjorgen	yes	no
Osteoporosis and/or fractures	yes	no
Degenerative disc disease (e.g back disease, spinal stenosis or severe chronic back pain)	yes	no
COPD, asthma, emphysema or other pulmonary disease	yes	no
Angina pectoris	yes	no
Myocardial infarction (heart attack)	yes	no
Heart failure (Any disease causing heart failure, e.g. atrial fibrillation or valve problems)	yes	no
Neurological disease (e.g. multiple sclerosis, Parkinson's disease)	yes	no
Dementia or other neurocognitive disorder	yes	no
Cerebrovascular accident (stroke)	yes	no
Peripheral vascular disease	yes	no
Diabetes mellitus type I or II	yes	no

Gastrointestinal disease	yes	no
Obesity and/or body mass index (BMI) > 30? Height: ___ in Weight: ____ lbs (BMI = weight/height)	yes	no
Depression (or other psychiatric diagnoses causing mood disturbances, e.g. bipolar disorder)	yes	no
Anxiety and or panic disorder	yes	no
Visual impairment (e.g. cataracts, glaucoma, macular degeneration)	yes	no
Hearing impairment	yes	no
Total Score: (yes =1; no =0)		
Cancer if yes type_____	yes	no
Chronic Fatigue syndrome	yes	no
Circulation problems	yes	no
Dizziness/Vertigo	yes	no
Fibromyalgia	yes	no
Headaches/migraines	yes	no
High blood pressure	yes	no
Implanted stimulator/pump and or Pacemaker/defribillator	yes	no
Incontinence	yes	no
Pregnancy if yes # of weeks ____	yes	no
Scoliosis	yes	no
Seizures	yes	no
Sleep apnea/difficulty	yes	no
Swallowing issues	yes	no
Thyroid issues	yes	no
Other medical conditions: Please list:		

Are you experiencing pain right now? **YES** **NO** Pain level 0-10 **Now**_____ **Best**_____ **Worst**_____

If yes, what increases your symptoms?_____

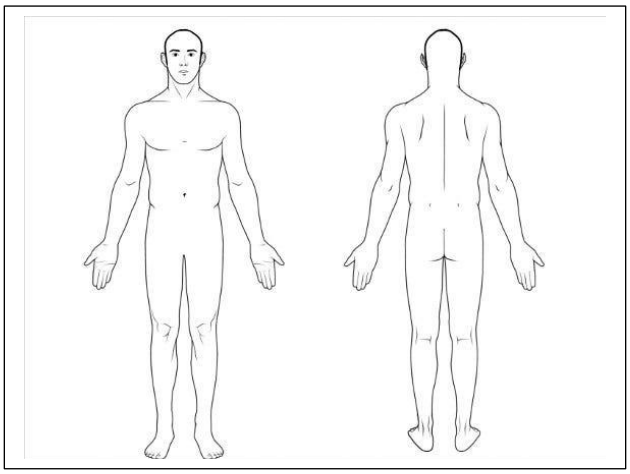
What decreases your symptoms? _____

Previous surgeries:_____

Please shade in the specific area(s)

where you are having symptoms

related to your current condition.



Do you have any of these symptoms:

Burning **Tingling**

Numbness **Swelling**

Location_____

Patient/Guardian Signature:_____ Date:_____

Therapist signature:_____ Date:_____ Time:_____