Sheltering Arms Institute
A collaboration with VCUHealth

Outpatient History Questionnaire

Preferred Pronouns: He She Ze They
Circle one

Name:_____ Date when current condition began: _____

Please describe your current condition:_____

What are your goals for therapy?_____

Are you experiencing pain right now? YES NO Pain level 0-10: Now_____ Best _____ Worst_____

Have you fallen in the past year?	**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**

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

Results:_____

*For the following, please circle **YES** if this disease **is** present in your medical history or **NO** if the disease **is NOT** present in your medical history.*

Diabetes mellitus type I or II	YES	NO	Arthritis (rheumatoid and/or arthritis)	YES	NO
Depression (or other psychiatric diagnoses causing mood disturbances, e.g. bipolar disorder)	YES	NO	Implanted stimulator/pump and or Pacemaker/defibrillator	YES	NO
Neurological disease (e.g. multiple sclerosis, Parkinson's disease)	YES	NO	COPD, asthma, emphysema or other pulmonary disease	YES	NO
Visual impairment (e.g. cataracts, glaucoma, macular degeneration)	YES	NO	Swallowing issues	YES	NO
Hearing impairment	YES	NO	Heart attack	YES	NO
Stroke/TIA	YES	NO	Heart disease, including heart failure	YES	NO
Sleep apnea/difficulty	YES	NO	Anxiety and or panic disorder	YES	NO
Chronic Fatigue syndrome	YES	NO	Scoliosis	YES	NO
Circulation problems	YES	NO	Thyroid issues	YES	NO
Dizziness/Vertigo	YES	NO	Osteoporosis and/or fractures	YES	NO
Fibromyalgia	YES	NO	Seizures	YES	NO
Headaches/migraines	YES	NO	Chest Pain	YES	NO
High blood pressure	YES	NO	Pregnancy if YES # of weeks	YES	NO
Latex allergy	YES	NO	Medication/food allergies	YES	NO
List Medication/food allergies:					
Other medical conditions: Please list:					

MEDICATION LIST

Patient/Guardian signature: _____ Date:_____

Therapist signature: _____ Date: _____ Time:_____

CLINICIAN USE ONLY BELOW LINE

Limber Pain Score: _____

Limber PROMIS Pain Interference:_____

Limber OUTCOME SCORE:_____

Limber OUTCOME NAME: _____