SUMMIT PACIFIC
• MEDICAL CENTER •

GENERAL HEALTH STATUS

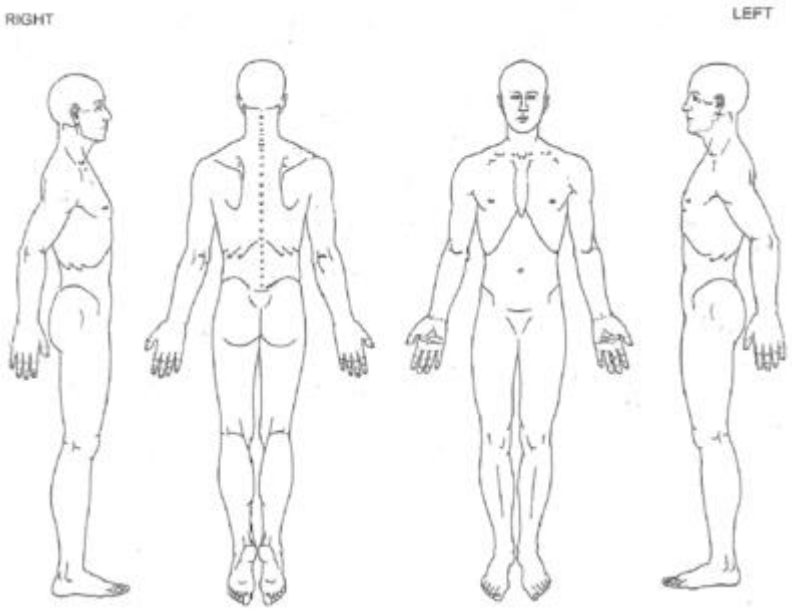
Name _____ Preferred Name _____Date of Birth_____
Rate your health: ___Excellent ___ Good ___ Fair ___ Poor Height: _____ Weight: _____
Sex _____ Gender _____ Are you currently receiving **Home Health** Services? □ Yes □ No
Occupation: _____ Was this an on the job injury? □ Yes □ No
Are you currently working? □ Yes □ No □ Light or Modified duty

CURRENT CONDITION/COMPLAINT

Describe the problem (s) for which you seek therapy. _____
_____
_____
When did the problem(s) begin? _____
What happened? _____
Have you ever had the problem(s) before? □ Yes □ No
If Yes: What did you do for the problem(s)? _____
Did the problem(s) get better? □ Yes □ No
How long did the problem(s) last? _____
What time of day is your pain/problem Best? _____ Worst? _____
Overall, do you feel the problem is: □ Getting better □ Getting worse □ Staying the same
What areas of your life are limited by your symptoms? _____
_____
Are you seeing anyone else for this problem? □ No □ Yes: _____
Pain Scale (0 = no pain, 10 = extreme pain) Currently _____/10 At worst _____/10 At best _____/10

Describe your pain/symptoms:
□ Dull □ Ache □ Sharp □ Stabbing
□ Shooting □ Tingling □ Burning
□ Throbbing □ Twinge □ Numb
□ Other _____
Is it constant? □ Yes □ No
Does it change with activity? □ Yes □ No
What makes it worse?
□ Sitting □ Standing □ Walking
□ Lifting □ Bending □ Lying down
□ Squatting □ Stress □ Reaching
□ Changing position
□ Other _____
What makes it better?
□ Sitting □ Standing □ Walking
□ Lying down □ Changing position
□ Rest □ Heat □ Cold □ Medication
□ Other _____

Please mark location of pain/symptom



Do you exercise beyond normal daily activities and chores? □ No □ Yes

Describe exercise: _____

a. On average, how many days per week? _____
b. How many minutes, on average? _____

Do you feel safe in your current home situation? □ Yes □ No
Are you being abused? □ Yes □ No

MEDICAL/SURGICAL HISTORY

Have you ever had any of the following?

o Diabetes Type ____	o Heart problems	o Cancer/Tumors
o Kidney problems	Specify _____	Specify _____
o High blood pressure	o Arthritis	o Seizures/epilepsy
o Multiple sclerosis	o Broken bones/fractures	o Pacemaker
o Circulation problems	o Muscular dystrophy	o Osteoporosis/Osteopenia
o Blood disorders	o Parkinson's disease	o Stroke
o Environmental allergies	o Lung problems	o Thyroid
o Head injury	o Skin diseases	o Repeated infections
o Depression	o Low blood sugar/hypoglycemia	o Ulcers/stomach problems
o Infectious disease (MRSA, C-Diff, Hepatitis)		o Developmental/growth problems
o Asthma/COPD	o Anxiety/PTSD	o Tobacco use/Vaping
o Fibromyalgia	o Other: _____	

Within the **past year**, have you had any of the following?

o Chest pain	o Difficulty sleeping	o Heart palpitations	o Loss of appetite
o Sudden weight loss/gain	o Nausea/vomiting	o Difficulty swallowing	o Hoarseness
o Shortness of breath	o Bowel problems	o Dizziness or blackouts	o Cough
o Coordination problems	o Urinary problems	o Weakness in arms/legs	o Vision problems
o Fever/chills/sweats	o Loss of balance/falls	o Headaches	o Pain at night
o Difficulty walking	o Hearing problems	o Joint pain/swelling	o Other: _____

Have you ever had surgery? □ Yes □ No
If yes, please describe, and include dates:

_____
_____
_____
_____

Allergies: List ***all*** allergies including environmental and medicine – □ No Known Allergies

_____
_____
_____

Medications (if you have a list available, please attach copy)

Name of Medication	Dose (if known)	Route (IV, oral, etc.)