PQRS Health Questionnaire – OT, ST & Multi-Discipline

Patient Name:_____ Date:_____

Section 1, Medications:

Please list your current medications, including: ***over the counter medications, vitamins/mineral/dietary supplements, prescription medications and any herbal supplements:***

For each medication, please list the following:

	Name of Medication/ Vitamin/Herbal Supplement	Dosage	Frequency	Route of Administration*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

*(Definition of route of administration: oral, subcutaneous, IV, etc.)

If more space is needed, continue on back of page.

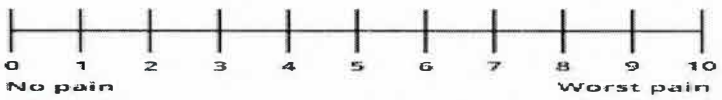
Section 2, Pain:

Do you have pain: Yes_____ No_____

If yes, please list where:_____

Using the pain scale below, please rate the amount of pain you have right now:_____

Using the pain scale below, please rate your pain when it is at it's worst:_____



Rate your pain or pain relief from 0-10

_____ I have completed this to the best of my knowledge
(Patient/Parent/Guardian's initials)

_____ Read and Reviewed
(Therapist's Initials)

Section 3, Falls:

Have you had 2 or more falls in the past 12 months? Yes_____ No_____

If yes, how many falls have you experienced in the past 12 months?_____

Have you had a fall that resulted in an injury in the past 12 months? Yes____ No_____

If yes, what kind of fall did you suffer and what was the subsequent injury?_____

_____

Section 4, Smoking:

Do you currently use tobacco or tobacco products? Yes_____ No_____

If yes, what type and how frequently:_____

Section 5, Alcohol Use:

How many times in the last year have you had 4 or more drinks?_____

Section 6, EASI:

1.) Have you relied on people for any of the following: bathing, dressing, shopping, banking or meals?	Yes	No	
2.) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides, or medical care, or from being with people you wanted to be with?	Yes	No	
3.) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	Yes	No	
4.) Has anyone tried to force to you sign papers or to use your money against your will?	Yes	No	
5.) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	Yes	No	

Medications, continued from front page:

	Name of Medication/ Vitamin/Herbal Supplement	Dosage	Frequency	Route of Administration*

_____ I have completed this to the best of my knowledge
(Patient/Parent/Guardian's initials)

_____ Read and Reviewed
(Therapist's Initials)

Health History Attachment:

Are you currently receiving services from Home Health providers (either nursing or therapy)? ___Yes ___No

Have you had a complete medical check-up in the last year? ___Yes ___No

Do you now have or have you recently had any of the following complaints:

- ☐ Pain or a feeling of heaviness in your chest
- ☐ Pulsating pain anywhere in your body
- ☐ Constant and severe pain in lower leg (calf)
- ☐ Frequent or severe abdominal pain
- ☐ Persistent pain at night
- ☐ Unexplained weight loss (10-15 lbs in 2 weeks)
- ☐ Unusual lumps or growths

Do you currently have or have you ever had any of the following medical conditions?

___Asthma	___Bronchitis	___Diabetes	___Hernia
___Heart Disease	___Chest Pain	___ Epilepsy	___Tuberculosis
___ Epilepsy	___Arthritis	___ High Blood Pressure	
___Cancer	___ HIV/AIDS	___Low Blood Pressure	
___Sickle Cell Anemia		___Other:_____	

_____ I have completed this to the best of my knowledge
(Patient/Parent/Guardian's initials)

_____ Read and Reviewed
(Therapist's Initials)