

MILLENNIUM REHABILITATION HEALTH QUESTIONNAIRE

Name: _____ Occupation: _____

Leisure Activities: _____

If you have seen any medical professional during the past three months, please describe for what reason (illness, medical conditions, physical, etc.): _____

Have you EVER been diagnosed with any of the following conditions:

YES	NO	Cancer	YES	NO	Multiple sclerosis
YES	NO	Heart Problems	YES	NO	Epilepsy
YES	NO	Circulation Problems	YES	NO	Anemia
YES	NO	Asthma	YES	NO	Hepatitis
YES	NO	Emphysema/Bronchitis	YES	NO	Tuberculosis
YES	NO	Chemical Dependency (i.e. alcoholism)	YES	NO	Stroke
YES	NO	Thyroid Problems	YES	NO	Kidney disease
YES	NO	Diabetes	YES	NO	Allergies
YES	NO	Arthritis	YES	NO	Depression

Please list any surgeries, or other conditions, that you have been treated for:

Please list any prescription, or over-the-counter medication, you are currently taking:

Have you fallen in the last year? _____ How many times have you fallen? _____
Did you sustain an injury when you fell and if so, please describe. _____

Under what circumstances did you fall? (location, assistive devices, transferring, etc.)

Returning Patients – Please update, sign and date

Patient Initials: _____ Date: _____

Patient Initials: _____ Date: _____

Therapist Initials: _____ Date: _____

Therapist Initials: _____ Date: _____