Patient Questionnaire

UnityPoint Health
St. Luke's Hospital

Therapy Medical Information

If you have previously been seen by a UnityPoint Health provider, your therapist can access your electronic medical record. Please take a moment to answer these additional questions for our team to better assist you.

NAME: _____ DATE: _____

PLEASE MARK "YES" OR "NO"

Are you receiving therapy or nursing services from a Home Health Agency?	☐ Yes	☐ No
Is transportation to or from therapy a concern for you?	☐ Yes	☐ No
Do you feel unsteady when walking or standing?	☐ Yes	☐ No
Has there been increased difficulty or more help needed with medications, cooking or driving?	☐ Yes	☐ No
Are you in a current relationship in which you have ever been hurt or threatened?	☐ Yes	☐ No
- If yes, would you like to speak with someone about this, or do you need resource information?	☐ Yes	☐ No
Are you now, or could you possibly be pregnant?	☐ Yes	☐ No
How many physical therapy visits have you received this calendar year at any clinic? _____		
At the present time, would you say your health is: ☐ Excellent ☐ Very good ☐ Good ☐ Poor		
How do you prefer to learn? ☐ Reading ☐ Listening ☐ Demonstration ☐ Pictures/Visual		

This information is complete and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

PATIENT LABEL