## HPI NEUROLOGY

### History of Present Illness

**Why are you here today? (Select one)**

- ○ a fall
- ○ decreased balance
- ○ decreased mobility
- ○ fatigue
- ○ pain
- ○ weakness
- ○ decreased endurance
- ○ decreased range of motion
- ○ neuropathy
- ○ a surgery

How would you describe your current problem:

**On what date did this occur?**

**Have you been hospitalized for your present illness?** Yes No

if yes, please list the date of admission and the length of stay.

**Do you have a neurological disease?** Yes No

If yes, select one of the following:

- ○ a stroke
- ○ Parkinson's disease
- ○ Multiple Sclerosis
- ○ a brain injury
- ○ a spinal cord injury
- ○ other

How would you describe your current problem?

- ☐ sudden
- ☐ progressive
- ☐ chronic
- ☐ relapsing/remitting
- ☐ other

**Do you have pain?** Yes No

**Which side? (Select all that apply)**

- ☐ left
- ☐ right

**Where is this pain located? (Select all that apply)**

- ☐ neck
- ☐ upper back
- ☐ shoulder
- ☐ arm
- ☐ hand
- ☐ mid back
- ☐ hip
- ☐ buttock
- ☐ leg
- ☐ ankle
- ☐ foot
- ☐ knee
- ☐ lower back
- ☐ face
- ☐ head

**What makes this pain worse? (Select all that apply)**

- ☐ running
- ☐ stair climbing
- ☐ kneeling
- ☐ jumping
- ☐ twisting
- ☐ pivoting
- ☐ squatting
- ☐ prolonged sitting
- ☐ standing
- ☐ bending
- ☐ sitting
- ☐ driving
- ☐ walking
- ☐ overhead reaching
- ☐ cough/sneeze/holding breath
- ☐ sleeping

**What makes this pain better? (Select all that apply)**

- ☐ nothing
- ☐ rest
- ☐ pain medication
- ☐ ice
- ☐ heat
- ☐ bracing
- ☐ cane/walker
- ☐ immoblization
- ☐ elevation
- ☐ cortisone injections
- ☐ sitting
- ☐ standing
- ☐ walking
- ☐ overhead reaching

**How would you describe this pain? (Select all that apply)**

- ☐ dull
- ☐ sharp
- ☐ aching
- ☐ throbbing
- ☐ shooting
- ☐ constant
- ☐ intermittent

**Do you have other symptoms?** Yes No

**What are the symptoms? (Select all that apply)**

- ☐ swelling
- ☐ buckling
- ☐ popping
- ☐ instability
- ☐ locking
- ☐ night pain
- ☐ radiation
- ☐ grinding
- ☐ bruising
- ☐ catching
- ☐ stiffness
- ☐ discoloration

**What hand is dominant? (Select one)** ○ right handed ○ left handed ○ ambidextrous (both)

**Have you had any diagnostic tests done? (Select all that apply)** Yes No

- ☐ Xray
- ☐ CT
- ☐ MRI

**Do you currently have numbness and tingling?** Yes No

If yes, where? (Select all that apply)

- ☐ right upper extremity
- ☐ left upper extremity
- ☐ right lower extremity
- ☐ left lower extremity

**Additional Comments:**

**Have you had any other forms of therapy previously?** Yes No

If yes, select the location where the therapy occurred. (Select all that apply.)

- ☐ inpatient rehabilitation center
- ☐ subacute rehabilitation center
- ☐ home rehabilitation
- ☐ outpatient rehabilitation
- ☐ skilled nursing facility

If yes, select the type of therapy received. (Select all that apply.)

- ☐ occupational therapy
- ☐ physical therapy
- ☐ speech therapy

If yes, when did you receive these therapies and for how long?

**Do you use any assistive devices?** Yes No

If yes, select all that apply.

- ☐ walker
- ☐ 4 point cane
- ☐ hoyer lift
- ☐ single point cane
- ☐ wheel chair/transfer chair
- ☐ other

**Do you have any adaptive equipment?** Yes No

If yes, select all that apply.

- ☐ ankle-foot orthosis
- ☐ sling
- ☐ shower chair
- ☐ raised toilet seat
- ☐ sock aid
- ☐ adapted utensils
- ☐ knee-ankle-foot orthosis
- ☐ brace
- ☐ bedside commode
- ☐ long handle reacher
- ☐ button hook
- ☐ other

**Have you ever had a pressure sore?** Yes No

if yes, where?

**Has your doctor given you precautions or restricted you from any of the following:**

- ☐ driving
- ☐ activity level
- ☐ swallowing/diet
- ☐ other
- ☐ lifting

## Home Environment

**How would you rate your health?** ○ excellent ○ good ○ fair ○ poor

**Do you exercise regularly?** ○ does ○ does not

**How many falls have you had in the past 6 months?** ○ 0 ○ 1 to 2 ○ >3

**What is your employment status?** ○ employed ○ unemployed ○ retired

What do you do for a living? _____

**Do you live alone?** ○ alone ○ with someone

**Do you require assistance at home?** Yes No

**Does anyone come to your home to provide health care services?** Yes No

If yes, select all that apply. ☐ nursing ☐ social work ☐ caregiver ☐ respiratory ☐ other

If yes, please list the agency name and phone number: _____

**Do you have stairs at home?** Yes No

If yes, how many? ○ 1-8 ○ 9-15 ○ >15

Where is the railing as you go up the stairs? (Select all that apply) ☐ left ☐ right

**What type of home environment do you live in?**

☐ house ☐ apartment
☐ condominium ☐ mobile home
☐ assisted living ☐ retirement center
☐ nursing home ☐ other

**Do you have multiple floors in your home?** Yes No

If yes, does the main level have a bedroom? Yes No

Does the main level have a bathroom? Yes No

Do you have a stair lift/elevator to get to other floors in your home? Yes No

**Do you have stairs to get into your home?** Yes No

If yes, do you have a ramp? Yes No

What entrance do you use most to get into your home? _____

## Goals/Followup

**What are your goals for therapy?**

**When are you scheduled to return to the doctor for follow-up?**

- ○ as needed
- ○ within 1 month
- ○ after completion of therapy

**Additional Comments:**

## Prior Level of Function

**Were you independent prior to this incident?** Yes | No

**If you were NOT independent prior to this incident, please check the activities you needed help with. (Select all that aply.)**

- ☐ bathing
- ☐ upper body dressing
- ☐ lower body dressing
- ☐ self feeding
- ☐ grooming
- ☐ toileting
- ☐ driving
- ☐ school work
- ☐ finance management
- ☐ housework
- ☐ cooking
- ☐ medication management
- ☐ yardwork
- ☐ other

**What life roles were impacted due to this incident? (Select all that apply.)**

- ☐ caregiver
- ☐ parent
- ☐ grandparent
- ☐ homemaker
- ☐ employee
- ☐ employer
- ☐ friend
- ☐ companion
- ☐ spouse
- ☐ volunteer
- ☐ student