Patient Name: _____ Date: _____

Date of Birth: _____ Parent/Guardian's Name: _____

Parent/Guardian's Phone Number: *Home:* _____ *Work:* _____ *Cell:* _____

Emergency Contact Name (other than parent/guardian): _____ Phone: _____ Attn #: _____

Pediatrician's Name: _____ Phone Number: _____

1. The patient is able to communicate in: ❑ English ❑ Spanish ❑ French ❑ Creole
   ❑ Sign language ❑ Other _____ ❑ Interpreter _____
2. The parent/guardian is able to communicate in: ❑ English ❑ Spanish ❑ French ❑ Creole
   ❑ Sign language ❑ Other _____ ❑ Interpreter _____
3. Does the patient have any religious, cultural, or spiritual practices that may alter their care or education? ❑ Yes ❑ No
   Please describe: _____
4. Do you have any financial concerns regarding the patient's therapy? ❑ Yes ❑ No
   If yes, please describe: _____
5. Describe the reason you need therapy: _____
   _____
6. What are the patient/family expectations/goals from therapy? _____
7. Has the patient ever received or is currently receiving treatment for this problem? ❑ Yes ❑ No
   Please describe: _____
8. Does the patient have any special needs and/or nutritional needs or concerns? ❑ Yes ❑ No
   If yes, what are they? _____
9. Does the patient have all of the vaccinations/immunizations for their age? ❑ Yes ❑ No
   If no, why? _____
10. Who do you consider family & who can we include in your care? _____
11. Who may we share your medical / rehabilitation progress with? _____

Medical History

Have you ever had, or do you currently have any of the following conditions? Check Yes or No, and indicate the dates as accurately as possible:

Medical Condition	Yes I've had	No I have not	If Yes, Dates of Occurrence	Medical Condition	Yes I've had	No I have not	If Yes, Dates of Occurrence
Attention Deficit Disorder or Attention Deficit / Hyperactivity Disorder				Irregular Heartbeat			
				Joint Replacement			
				Open Wounds			
Arthritis				Osteoporosis			
Autism				Pacemaker			
Bowel/Bladder Problems				Pervasive Developmental Disorder			
Brain Injury				Pregnancy			
Cancer				Psychiatric Care			
Chemotherapy				Radiation Therapy			
Diabetes				Seizures			
Difficultly Breathing				Skin Problems			
Fractures				Stroke			
Heart Disease				Surgery			
Hepatitis				Tuberculosis			
Hernia				Vascular Disease			
High Blood Pressure				Other:			

10. Have you had surgery? ❑ Yes ❑ No If yes, please give types and dates for the procedures? _____

_____

11. Please list allergies: ❑ None _____

12. Are you following any precautions? Have you been told things to avoid? ❑ None ❑ Yes
(Please list): _____

Medications

1. Please list all the medications you are taking ❑ None _____

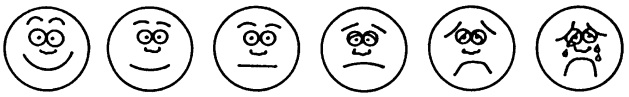
_____

2. Please list all over the counter medications, herbals and supplements you are taking ❑ None _____

_____

Pain Management

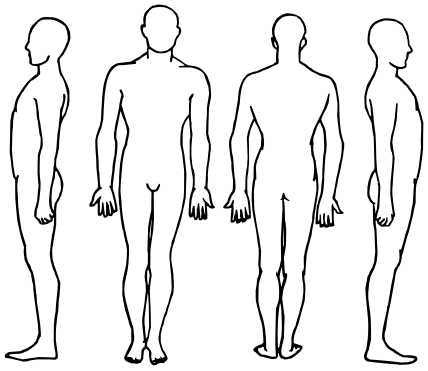
1. Do you have any pain? ❑ Yes ❑ No
2. Have you had any pain recently? ❑ Yes ❑ No If yes, when _____
3. When did your pain start? _____
4. Duration of pain: ❑ Constant ❑ 75% of the time ❑ 50% of the time ❑ 25% of the time
5. Severity of pain (please use the scale BELOW to determine your levels)



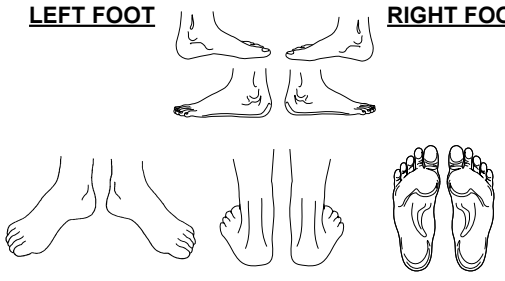
0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

Current pain level: _____
Pain level at best: _____
Pain level at worst: _____

6. What kind of pain do you feel? ❑ Aching ❑ Burning ❑ Crushing ❑ Dull ❑ Excruciating
❑ Pressure ❑ Sharp ❑ Stabbing ❑ Stiffness ❑ Throbbing ❑ Unable to describe
❑ Other _____
7. What aggravates the pain? _____
8. What decreases the pain? _____
Is it effective: ❑ all of the time ❑ most of the time ❑ some of the time
❑ temporary relief ❑ not effective
9. Location of the pain (indicate location with an X). Does your pain travel or radiate from one part of the body to another?
❑ Yes ❑ No



LEFT FOOT **RIGHT FOOT**

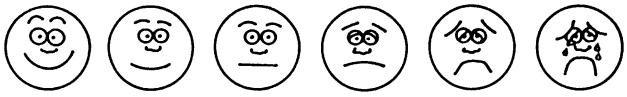


Memorial Healthcare System

OUTPATIENT REHABILITATION
ADOLESCENT PATIENT INFORMATION

PATIENT/LABEL

10. What is an acceptable pain level for you upon **completion** of your therapy?
Circle one:



0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

Current pain level: _____
Pain level at best: _____
Pain level at worst: _____

FUNCTIONAL INFORMATION

1. Do you live: ❒ Alone ❒ with Family ❒ Significant Other ❒ Aide/Nurse # of hours _____
2. Home Environment:
❒ Apartment/Condominium ❒ House ❒ Mobile Home ❒ Other: _____
❒ Stairs / Steps (# _____) ❒ Elevator ❒ Ramp
3. Adaptive Equipment/Assistive Devices: _____

_____

_____

4. Daily Living Activities: (What activities are you unable to perform?)
A. ❒ Bathing ❒ Dressing ❒ Toileting ❒ Walking ❒ Squatting
❒ Homemaking ❒ Writing/ Grasping ❒ Lifting/ Bending ❒ Concentration ❒ Grooming
❒ Driving ❒ Communication ❒ Swallowing ❒ Leisure Activities ❒ Sports
❒ Sleep ❒ Relationships ❒ Reaching ❒ Job related Tasks
❒ Self Care/Hygiene ❒ Other Activities _____

B. For any boxes checked, describe specific task limitations: _____

_____

EDUCATION

1. How do you learn best? ❒ Written ❒ Visual/demonstration ❒ Verbal ❒ Other _____
2. Highest level of education you have completed? _____
3. I would like to learn about: ❒ home exercise program ❒ pain management techniques ❒ support groups
❒ quitting smoking ❒ weight loss ❒ stress management techniques ❒ Other: _____

I have provided accurate information to the best of my knowledge and have received orientation to Outpatient Rehabilitation. I have read and understand them. I understand it is my responsibility to advise my therapist of any unexpected changes in my condition, changes in medication, or additional treatments I am receiving. I will actively participate in the decision making process and be involved in my treatments, and will express any concerns to my therapist. I acknowledge that I am responsible for the outcome, if I do not comply with the treatment plan.

Patient / Family Signature: _____ Date: _____

To be completed by the therapist:

1. Signs and symptoms of abuse or neglect noted: ❑ Yes ❑ No
   If yes, what action was taken: _____
2. Admission Packet Issued: ❑ Yes ❑ No If no, reason: _____
   ❑ Fall Prevention Program initiated
3. Potential barriers to learning are: ❑ age ❑ financial ❑ cognitive ❑ religious ❑ physical
   ❑ level of education ❑ communication ❑ cultural beliefs / values ❑ none
4. **Educational Needs** *(determined by patient and therapist):*

❑ ADL / Functional Training	❑ Home Exercise Program	❑ Pain Management
❑ Body Mechanics	❑ Home Modifications	❑ Posture
❑ Bowel/Bladder Diary	❑ Lymphedema Precautions	❑ Prevention
❑ Communication	❑ Medical Equipment	❑ Self Bandaging/MLD
❑ Community Resources	❑ Mobility	❑ Self Mobilization Techniques
❑ Diagnosis	❑ Newborn Care	❑ Wound Care
❑ Discharge Planning	❑ Nutrition	❑ Voiding
❑ Gait Training	❑ Occupation	❑ Other _____

	Therapist's Signature	Therapist's ID #	Date Eval Initiated
Physical Therapist			
Occupational Therapist			
Speech Language Pathologist			
Audiologist			