Name: _____ Date _____

Date of Birth: _____ Age _____ **Phone Number** Home: _____

Work: _____ Cell: _____

EMERGENCY CONTACT:

Name _____ Relationship _____ Phone: _____

GENERAL INFORMATION:

1. I am able to communicate in: ❒ English ❒ Spanish ❒ French ❒ Creole ❒ Sign language
   Other _____ Interpreter _____
2. Do you have any religious, cultural, or spiritual practices that may alter your care or education?
   ❒ Yes ❒ No, Please describe _____
3. Do you have any financial concerns regarding your therapy? ❒ Yes ❒ No
   If yes, please describe: _____
4. Why did your doctor send you for therapy? _____
   _____
5. What are your goals/expectations from therapy? _____
6. Have you ever received or are currently receiving treatment for this problem? ❒ Yes ❒ No
   Please describe: _____
7. Current employment / Occupation: _____
8. Do you have any special needs and/or nutritional needs or concerns? ❒ Yes ❒ No
   If yes, what are they? _____
9. Whom do you consider your family & who can we include in your care? _____
10. Who may we share your Medical / Rehab 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
Arthritis				Joint Replacement			
Bowel/Bladder Problems				Multiple Sclerosis			
				Open Wounds			
Brain Injury				Osteoporosis			
Cancer				Pacemaker			
Chemotherapy				Pregnant			
Diabetes				Psychiatric Care			
Difficultly Breathing							
Fractures				Radiation Therapy			
Heart Disease				Seizures			
Hepatitis				Skin Problems			
Hernia				Stroke			
High Blood Pressure				Tuberculosis			
				Vascular Disease			
Irregular Heart Beat							
				Other:			

11. Have you had surgery? ❑ Yes ❑ No If yes, please give types and dates for the procedures? _____
    _____
    _____
12. Please list allergies: ❑ None _____
13. Are you following any precautions? Have you been told things to avoid? ❑ None ❑ Yes
    (Please list): _____

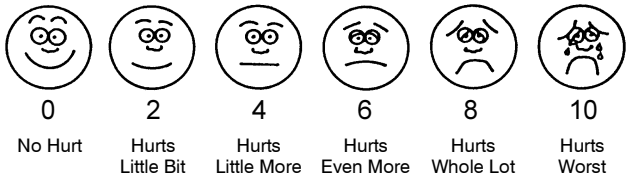
Medications

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

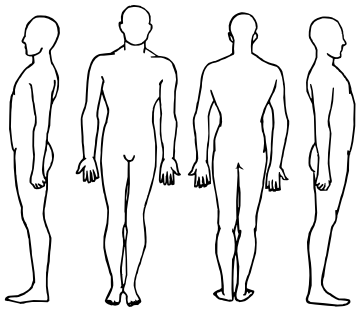
Pain Management

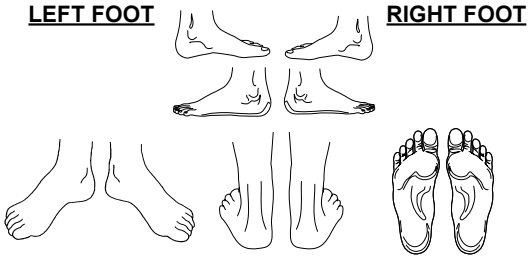
1. Do you have any pain? ❑ Yes ❑ No
2. Have you had any pain recently? ❑ Yes ❑ No If yes, when? _____
3. When did your pain start? _____
4. Duration of pain: ❑ Constant ❑ 75% of the time ❑ 50% of the time ❑ 25% of the time
5. Severity of pain (please use the scale RIGHT to determine your levels)

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

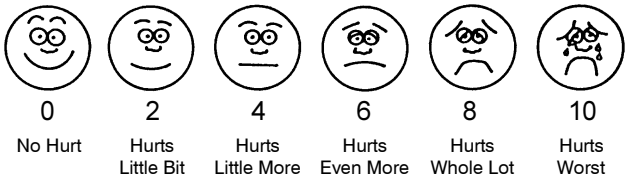


6. What kind of pain is the patient feeling? ❑ Aching ❑ Burning ❑ Crushing ❑ Dull ❑ Excruciating
   ❑ Pressure ❑ Sharp ❑ Stabbing ❑ Stiffness ❑ Throbbing ❑ Unable to describe
   ❑ Other _____
7. What aggravates the pain? _____
8. What decreases the pain? _____
   Is it effective: ❑ all of the time ❑ 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





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



FUNCTIONAL INFORMATION

1. Do you live: ❒ Alone ❒ with Spouse/ 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 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 all 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: _____
3. Fall Prevention Program initiated: ❒ Yes ❒ No
4. Potential barriers to learning are: ❒ age ❒ financial ❒ cognitive ❒ religious ❒ physical ❒ level of education ❒ communication ❒ cultural beliefs/values ❒ none
5. Education 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			