REHABILITATION SERVICES OUTPATIENT INTAKE FORM

Today's date: ________________ **MR#:**________________________

Name: ____ **Birthdate:** __________________ **Sex:** ☐ **Male** ☐ **Female**

SOCIAL HISTORY/ LIVING ENVIRONMENT:

With whom do you live?
_____ Alone
_____ Spouse only
_____ Spouse and other(s)
_____ Child
_____ Other relative(s)
_____ Group setting
_____ Personal care attendant
_____ other: _____________________

Where do you live?
____Private home
____Private apartment
____Rented room
____Board and care/ assisted living/group home
____Homeless (with or without shelter)
____Long term care facility (nursing home)
____Hospice
____Other:____________________________

Employment:
_____ Working full-time outside of home
_____ working full-time from home
_____ working part-time outside of home
_____ working part-time from home
_____ Homemaker
_____ Student
_____ Retired
_____ Unemployed
If employed, occupation: __________

Cultural/ Religious: Any customs or religious beliefs or wishes that might affect care? ______________________________________

Have you completed an advanced directive? (Living will, medical power of attorney, or Do Not Resuscitate) ____YES ___NO (attach copy if available)

ALLERGIES: ____

GENERAL HEALTH STATUS: Please rate your health: _____ Excellent _____ Good _____ Fair _____Poor
Have you had any major life changes during the past year (eg, new baby, job change, death of a family member)? ___Yes ___ No

MEDICAL/ SURGICAL HISTORY:
a) Please check if you have ever had any of the following:

____ Allergies: __________________
_____ Arthritis
_____Blood disorders
_____Broken bones/ fractures
_____Cancer
_____Circulation/ vascular problems
_____Depression
_____Diabetes/ high blood sugar
_____Head injury
_____Heart problems
_____High blood pressure
_____Infectious disease
_____Kidney problems
_____Lung problems/ pneumonia
_____Low blood sugar/ hypoglycemia
_____Multiple sclerosis
_____Osteoporosis
_____Parkinson disease
_____Repeated infections
_____Seizures/ epilepsy
_____Skin diseases
_____Stroke
_____Swallowing difficulties
_____Thyroid problems
_____Ulcers/ stomach problems
_____Other:__________________

b) Within the last year, have you had any of the following symptoms? (Check all that apply)

_____ Chest pain
_____ Heart palpitations
_____ Cough
_____ Hoarseness
_____ Shortness of breath
_____ Dizziness or blackouts
_____ Coordination problems
_____ Weakness in arms or legs
_____ Loss of balance or falls
_____ Difficulty walking
_____ Joint pain or swelling
_____ Pain at night
_____ Difficulty sleeping
_____ Loss of appetite
_____ Nausea/ vomiting
_____ Difficulty swallowing
_____ Bowel problems
_____ Weight loss
_____ Urinary problems
_____ Fever/ chills/ sweats
_____ Headaches
_____ Hearing problems
_____ Vision
_____ other: ___________________

LIST ANY SURGERIES AND DATES:

OTHER CLINICAL TESTS: Please check any tests that you have had done within the past year:

_____ Angiogram
_____ Arthroscopy
_____ Biopsy
_____ Blood tests
_____ Bone scan
_____ Bronchoscopy
_____ CT scan
_____ Doppler ultrasound
_____ Echocardiogram
_____ EEG (electroencephalogram)
_____ EKG (electrocardiogram)
_____ EMG (electromyogram)
_____Mammogram
_____Modified Barium Swallow Study
_____MRI
_____NCV
_____Pap smear
_____Pulmonary function test
_____ Spinal tap
_____ Stool tests
_____ Stress test (treadmill/ bike)
_____ Urine tests
_____ X-rays
_____Other:____________

MEDICATIONS: List any prescription medications you take:
____

____

List any nonprescription medications you take:
____

CURRENT CONDITION(S)/ CHIEF COMPLAINT(S)

a) Describe the problem for which you seek treatment:_______________________________

____

b) When did the problem(s) begin (date):______________________________

c) What happened? ____

d) Have you ever had the problem before? If yes, what did you do for the problem: _______________

____

Did the problem get better? _____ Yes _____ No How long did the problem last? _________________

e) How are you taking care of the problem now? ______________________________________

f) What makes the problem better?
____

g) What makes the problem worse?
____

h) What are your goals for therapy?
____

I) Who referred you to therapy? ____

j) Are you seeing anyone else for the problem(s)? If so, please provide their names:
____

FUNCTIONAL STATUS/ ACTIVITY LEVEL: (check all that apply)

a) _____ Difficulty with locomotion/ movement: _____ bed mobility _____ transfers (bed to chair, on/off commode)
gait (walking): _____ on level _____ on stairs _____on ramps _____ on uneven terrain
b) _____ Difficulty with self care (such as bathing, dressing, eating, toileting)
c) _____ Difficulty with home management (household chores, shopping, driving, care of dependents)
d) _____ Difficulty with community and work activities: ____ work/ school _____ recreation or play activities

Does your home have:
_____ Stairs, no railing
_____ Stairs, railing
_____ Ramps
_____ Elevator
_____ Uneven terrain
_____ Modifications (bathroom)
_____ Any obstacles: ______________

Do you use?
_____ Cane
_____ Standard Walker
_____ Walker with wheels
_____ Manual Wheelchair
_____ Motorized wheelchair
_____ Glasses, hearing aids
_____ other: _______________

This outpatient rehabilitation intake form has been reviewed and verified as accurate with the patient and/or surrogate by the evaluating therapist. Patient is aware of "Notice of Privacy Practices" and is aware of "Patients Rights". The patient did / did not request a written copy of these forms. If requested, a copy of the forms was given to the patient.

____
Patient/ surrogate signature and date

____
Therapist signature and date