



Care | Competence | Compassion | Courtesy

REHABILITATIVE SERVICES

Please fill the following information out. It will assist your therapist with your treatment. Please skip any questions you do not feel apply to you.

Name:	Date of Birth:
Doctor:	Today's Date:
Reason for therapy:	Date Symptoms Began:
Current Medications: (Include herbal & vitamins)	Allergies (drug, latex, tape, environmental):

Do you have any educational needs, such as information about your medications or diagnosis?
 Yes: _____ No:

Contacting Information:

- Who can we talk to about your health related information (name and relationship): _____
- If we need to contact you regarding appointment changes where/with whom can we leave a message?
 (check all that apply):
 - spouse
 - family
 - other: _____
 - home answering machine
 - work
 - cell phone

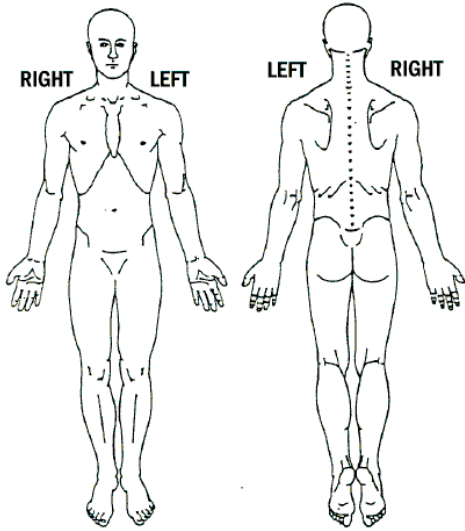
Personal Data:

- Do you live alone or with spouse family friend significant other other: _____
- Are you right handed left handed
- Do you consider yourself active moderately active inactive
- Are you presently working?
 - Yes: Describe work: _____
 - No (Date off: _____) Why (retired, light duty, injury): _____
- Sleeping habits: What is your typical sleeping position? Side Back Stomach
 Does pain wake you up at night? No Yes: How often? 1-2 times 3-4 times more than 4

Complaints:

- Please describe your major complaint or problem: _____
- Rate your **AVERAGE** pain on a scale of 0 to 10 where **0=no pain** and **10= worst possible pain** you can imagine
 0 1 2 3 4 5 6 7 8 9 10
- Rate your **WORST** pain on a scale of 0 to 10 where **0= no pain** and **10= worst possible pain** you can imagine
 0 1 2 3 4 5 6 7 8 9 10
- Please describe your pain (check all that apply)
 - Sharp Constant Aching Burning Other: _____
 - Dull Intermittent Radiating Numb/Tingling _____
- What causes your pain to increase?
- What causes your pain to decrease?

Please mark on the diagram the location of your complaints.



Other (please list): _____

History:

1. How did your problem start?

2. How has it changed since then?

- Better
- Worse
- Same

3. What are **your** goals for treatment?

4. Please check all of the following items that you are having difficulty with:

- | | | |
|---|--|---|
| <input type="checkbox"/> Memory | <input type="checkbox"/> Cleaning/Chores | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Laundry | <input type="checkbox"/> Hobbies |
| <input type="checkbox"/> Writing | <input type="checkbox"/> Reaching | <input type="checkbox"/> Yard Work |
| <input type="checkbox"/> Computer | <input type="checkbox"/> Lifting | <input type="checkbox"/> Job |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Walking | <input type="checkbox"/> Child Care |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Sitting | <input type="checkbox"/> Swallowing |
| <input type="checkbox"/> Make-up/Shaving | <input type="checkbox"/> Standing | <input type="checkbox"/> Eating |
| <input type="checkbox"/> Sexual Relations | <input type="checkbox"/> Bending | <input type="checkbox"/> Voice |
| <input type="checkbox"/> Cooking | <input type="checkbox"/> Social Activities | <input type="checkbox"/> Speech/Talking |

5. Do you have a history of any of the following:

- Current pregnancy** (weeks: _____)
- Arthritis
- Osteoporosis
- High Blood Pressure
- Bowel or Bladder problems
- Diabetes
- Heart Attack (MI)
- Brain Injury
- Cerebral Palsy
- Fractures (Broken Bones)
- Implanted Electrical Device (Pacemaker, Drug Delivery System)
- Other: _____

Current Diet:

- Cancer
- Smoking (Pack per day: _____)
- High Cholesterol
- Alcohol Use
- Respiratory Illness (Asthma, COPD, Emphysema)
- Stroke/Mini-Stroke (TIA)
- Spinal Cord Injury
- Multiple Sclerosis
- Lupus
- Regular
- Low Salt
- Low Sugar
- Low Fat
- Parkinson's
- Alzheimer's
- Heart arrhythmia

6. Any recent unexplained weight loss? Yes No

7. Are you being seen currently or have you been seen in the last 12 months by this or another facility/agency (PT, OT, ST, Home Health, Chiropractor) Yes No If yes: Where? _____ When? _____

8. Please list any surgeries or procedures you have had:

Procedure:	Date:	Procedure:	Date:

9. Have you had the following tests RELATED TO **THIS** INJURY:

<input type="checkbox"/> X-rays	Results:	<input type="checkbox"/> MRI	
<input type="checkbox"/> CT Scan		<input type="checkbox"/> Injections	