MAGEE REHABILITATION HOSPITAL

Email Address: _____

OUTPATIENT THERAPY NETWORK Date: _____

Initial Patient Intake Form

Name:_____DOB: _____ MR#:_____

Diagnosis:_____Physician Name: _____

HISTORY OF CURRENT PROBLEM

- What is the problem?
- What is the onset date for the problem (mm/dd/yyyy)?
- What caused the problem?
- What makes the problem better/worse?
- Have you had any prior treatment for this problem/condition?
- Have you had this problem/condition before? ◯YES ◯ NO
  - If YES, Did you get better?: YES ◯ NO ◯ SOMEWHAT

MEDICAL HISTORY

Do you have an out of hospital **DO NOT RESUSCITATE ORDER or POLST form**?◯Y ◯N

If yes, please provide a copy. Copy provided? ◯YES ◯NO Date received _____.

Do you have any **INTERNAL STIMULATORS**? **(Please circle ALL that apply):**

☐ PACEMAKER ☐ INTERNAL DEFIBRILLATOR ☐ DEEP BRAIN STIMULATOR

Have you ever been diagnosed with or treated for the following (hospitalization included)?
PLEASE CHECK ALL THAT APPLY

	YES	DATE
Alcohol Abuse	☐	
Anemia	☐	
Arthritis/ Rheumatism/ Gout	☐	
Asthma	☐	
Bleeding Tendency	☐	
Bowel Disorder/ Colitis	☐	

	YES	DATE
Gall Bladder Disease	☐	
Head Injury/Loss of Consciousness	☐	
Heart Problems or Increased Cholesterol	☐	
High Blood Pressure	☐	
Hepatitis	☐	
Kidney, Bladder,	☐	

PATIENT NAME: _____ MR#:_____

			Prostate Problems		
Cancer/ Tumors			Nervous/Emotional Problems		
Depression			Osteoporosis		
Diabetes			Phlebitis		
Drug Abuse			Stomach Problems/ Ulcers		
Emphysema/Bronchitis			Stroke		
Epilepsy/Seizures			Tuberculosis		
Falls/Loss of Balance			Other:		

Have you had surgery for any reason including any of the above conditions? ○YES ○NO

If YES, please list and include dates:

Have you had any of the following within the past year? (Please circle <u>ALL</u> that apply)

- ☐ Bowel/Bladder problems
- ☐ Chest pain
- ☐ Coordination problems
- ☐ Cough
- ☐ Difficulty sleeping
- ☐ Difficulty swallowing
- ☐ Dizziness/ blackouts
- ☐ Falls/ Balance problem
- ☐ Fever/ chills/ sweat
- ☐ Headaches
- ☐ Hearing problems
- ☐ Heart palpations
- ☐ Hoarseness
- ☐ Joint pain swelling
- ☐ Loss of appetite
- ☐ Nausea/ vomiting
- ☐ Night pain
- ☐ Shortness of breath
- ☐ Urinary problems
- ☐ Vision problems

Other: _____

Please **<u>EXPLAIN</u> any circled items:

Have you had any weight gain/loss (> 10 pounds) in the past month? ○YES ○NO

If YES, how much? _____ Pounds Current height _____ Weight _____

<u>Medications:</u>

Do you have any known adverse and allergic drug reactions: ○YES ○NO

If YES, List:_____

PATIENT NAME: _____ MR#:_____

Please list ALL current medications and prescribing physician:

Prescription medications: _____

_____

Non prescription medications: _____

_____

Vitamins/ minerals/supplements: _____

The following questions ask about your PAIN:

PAIN SCALE: 0 (no pain) <---------->10 (worst pain)

My CURRENT pain is rated as: _____ Location: _____

At WORST, my pain is 0 – 10: _____ At BEST, my pain is 0 – 10: _____

Pain/Current Condition limits which of the following?

(Please circle ALL that apply)

- ☐ Movement
- ☐ Walking (at home, level ground, uneven ground, ramps, curbs, stairs)
- ☐ Standing
- ☐ Sitting Self Care (Bathing, Dressing, Eating, and Toileting)
- ☐ Lifting
- ☐ Home Management (Cleaning, Shopping, Chores)
- ☐ Bending
- ☐ Getting In and Out of Bed
- ☐ Driving
- ☐ Work activities
- ☐ Leisure activities

Other: _____

SOCIAL HISTORY

Health Habits:

Do you smoke? ◯ YES ◯ NO # _____Packs per day Quit (Year) _____

How many days do you exercise in an average week? _____

How long is your average exercise session? _____

Describe the exercise: _____

Employment:

(Please circle ALL that apply)

- ☐ Full time
- ☐ Part time
- ☐ Unemployed
- ☐ Retired
- ☐ Inside home
- ☐ Disability
- ☐ Student

Occupation: _____

PATIENT NAME: _____ MR#:_____

If you are not currently working, do you plan to return to work? ◯YES ◯ NO
Are you interested in changing jobs? ◯YES ◯ NO

Home Set-Up:

Please Circle: ◯1-Story Home ◯ Multi-Story Home ◯ Apartment Other: _____

steps to enter: _____ with right rail/ left rail ☐ ramp ☐ elevator

steps to go upstairs: _____ with right rail/ left rail ☐ stair glide ☐ elevator

steps to go to basement: _____with right rail/ left rail ☐stair glide ☐elevator

Do you have a 1st floor set-up (Bed and Bathroom)? ◯YES ◯NO

Who do you live with? (Please circle <u>ALL</u> that apply)

☐ Alone ☐ Parent ☐ Spouse ☐ Children ☐ Significant other

Parent (please specify):_____

Other (please specify):_____

Do you have any attendant care? ◯YES◯NO Hours/day_____ Days/week_____

Do you have/use any medical equipment? (Please circle <u>ALL</u> that apply)

☐ Cane ☐ Walker (without wheels) ☐ Quad Cane
☐ Crutches ☐ Walker (with wheels) ☐ Bracing
☐ Orthotics ☐ Prosthesis ☐ Electric Stimulation
☐ Shower Chair ☐ DevicesManual Wheelchair
☐ Commode ☐ Power Wheelchair

Other: _____

Cultural/ Religious:

Do you have any customs or religious beliefs that may affect care? ◯YES ◯NO

List 4 goals for therapy:

1.
2.
3.
4.

PATIENT NAME: _____ MR#:_____

Do you have any other concerns or needs that we can be of assistance with?

_____

_____

_____

REGISTRATION STAFF USE ONLY

Discussed Cancellation/No-Show Policy with patient?
Please circle: ◯ YES ◯ NO

Discussed Patient Health Profile with patient?
Please circle: ◯ YES ◯ NO

Patient's initials: _____ **Registration Staff initials: _____**

CLINICIAN STAFF USE ONLY

1. Patient understands and can apply basic information:
◯ YES ◯ NO ◯ SOMEWHAT (Requires reinforcement)

2. Learning readiness of patient: ◯ Ready ◯ Not Ready ◯ No Interest ◯ Declines

3. Learning barriers: ☐ None ☐ Vision ☐ Hearing ☐ Language→Interpreter Needed
☐ Unable to Read/ Comprehend What is Read
Other: _____

4. How does patient best learn? ◯ Pictures ◯ Reading ◯ Listening ◯ Demonstration
Other: _____

Therapist's signature(s) _____Date: _____ Time: _____

_____ Date: _____ Time: _____