



2REHAB

To insure that you receive a complete and thorough evaluation along with referrals for any additional care required, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

Name: _____ Diagnosis: _____

Reason for coming to therapy: _____

Have you had this problem before? Yes No If yes, explain: _____

Have you had therapy for this condition before? Yes No

Your goals for therapy: _____

Are you *CURRENTLY* receiving home healthcare services? Yes No If yes, explain: _____

Occupation: _____

Leisure activities/hobbies: _____

Check all of the following providers whose care you are CURRENTLY receiving or have received in the PAST year.

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Psychiatrist/Psychologist | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Physical therapist | <input type="checkbox"/> Podiatrist | <input type="checkbox"/> Dentist |
| <input type="checkbox"/> Occupational therapist | <input type="checkbox"/> Speech therapist | <input type="checkbox"/> Home health |
| <input type="checkbox"/> Ophthalmologist | <input type="checkbox"/> Other _____ | |

Have you ever been diagnosed with or currently have any of the following conditions? (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Cancer, what kind: _____ | <input type="checkbox"/> Arthritic conditions | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Heart problems or heart attack | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Headaches or TMJ dysfunction | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke or TIAs | <input type="checkbox"/> Epilepsy or seizures |
| <input type="checkbox"/> Emphysema/bronchitis | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Chemical dependency (drug, alcohol) | <input type="checkbox"/> Metal implants or pacemaker | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Other _____ | | |

FOR WOMEN: Are you currently pregnant or think you MIGHT be pregnant? Yes No

Have you recently noted:

- | | |
|---|--|
| Weight loss or gain? <input type="checkbox"/> Yes <input type="checkbox"/> No | Fever, chills, or sweating? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nausea or vomiting? <input type="checkbox"/> Yes <input type="checkbox"/> No | Numbness or tingling? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have difficulty hearing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Right <input type="checkbox"/> Left | Weakness? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Right <input type="checkbox"/> Left | Fatigue? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you require communication devices? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type _____ | |

General Health Status

At the present time, would you say your health is:

- Excellent Very Good Fair Poor

Fall Assessment Needs

- Have you fallen in the past six (6) months? Yes No
- Do you take ANY of the following prescription medications: narcotics, high blood pressure medication, diuretics (water pills), heart medication? Yes No
- Do you feel dizzy when you get up from a chair or bed? Yes No
- Do you have uncorrected vision problems with reading or driving? Yes No
- Are you over 65 years of age? Yes No
- *If you answered yes to 2 or more questions, you could be at risk for a fall. (Therapist-further assessment may be indicated)

Functional Needs

- Have you had a significant DECREASE in your ability to perform any of the following items in the last 3 months?
- Dressing yourself (including shoes, socks, zippers, buttons)? Yes No
- Feeding yourself (including eating meat, handling utensils)? Yes No
- Increased choking or problems with swallowing? Yes No
- Slurred speech? Yes No
- Problems with remembering the names of objects? Yes No
- Grooming (including shaving, combing your hair, reaching the top and back of your head)? Yes No
- Walking (including increasing dependence on a walker or cane)? Yes No
- Stair climbing or walking up and down curbs or inclines? Yes No
- Changes in balance or coordination (falls)? Yes No

Social Service Needs - Please indicate whether any of the following are true:

- Do you live alone? If no, with whom? _____ Yes No
- Do you have access to transportation? Yes No
- Are you depressed? Yes No
- Do you need a caregiver at home, or are you having difficulty with the caregiver that you do have? Yes No
- Is English your primary language? If no, please list primary: _____ Yes No
- Can you read/understand English language? Yes No
- Where do you live? House Apartment Trailer Assisted Living Nursing Home Other _____

Referrals Made to the Following:

Service:	Date:	By:
_____	_____	_____
_____	_____	_____

Fall Assessment indicated based on screening and will be documented on the initial evaluation.

Therapist Signature _____ Date _____ Time _____
(This form has been reviewed with the patient.)

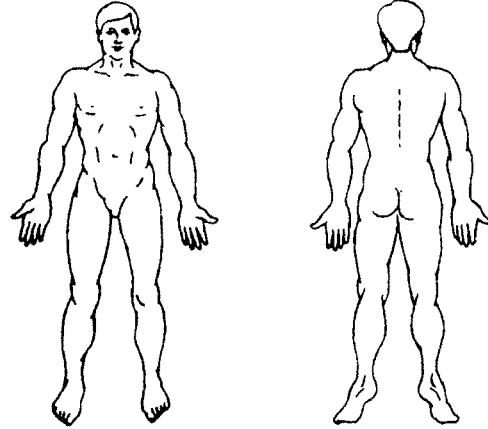
PAIN SELF ASSESSMENT

Where is your pain?

(On the diagram below indicate pain location by shading the area involved. Refer to the key and place numbers that correspond to the pain's character over the appropriate shaded area. Also indicate area of numbness, ONLY if related to present injury or condition.)

Key

- 1. Dull ache
- 2. Stabbing
- 3. Pins and Needles
- 4. Burning
- 5. Numbness
- 6. Other _____



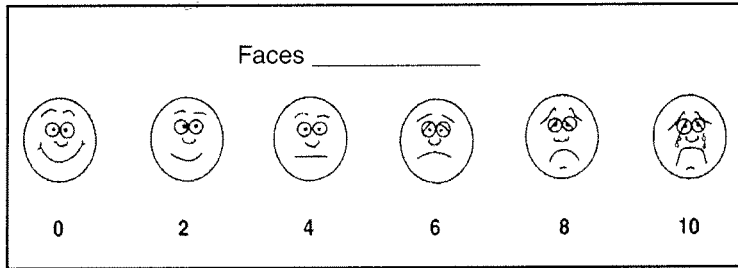
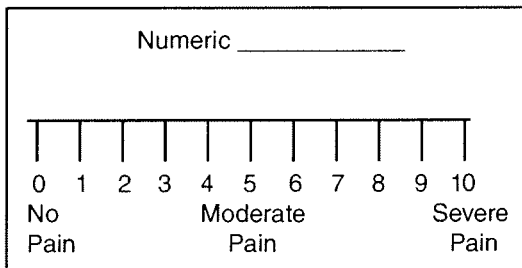
Pain Related Issues

Are you having pain now? Yes No

(If you answered "yes", use one of the scales below to choose the number that best describes your present level of pain.)

What is your goal for pain relief? (number _____ face _____ that represents your goal)

What would be an acceptable level of pain? (number _____ face _____ represents that level):



What methods of pain relief have you tried?

- Heat
- Cold
- Relaxation/distraction
- Over counter pain medications
- Physical therapy
- Other _____
- Herbal/homeopathic
- Medications _____

Were they successful in relieving your pain? Yes No

What activities make your pain worse? _____

What activities lessen your pain? _____

Person Completing Form

Patient/caregiver signature: _____ Date: _____ Time: _____

SUMMARY LIST -Allergies, Medications, Significant Injury or Surgery

Patients: Complete **only unshaded sections by 3rd visit**. Upon each visit the patient summary listed is reviewed. Documentation is only required if there are any changes in diagnosis, medications, allergies to medications, procedures performed or a change in medical status. These changes are documented below.

ALLERGIES None See Attached

List all allergies:

Allergy update to be completed by therapist if changes occur:

	Date	Therapist Initials
<hr/>		
<hr/>	Date	Therapist Initials

MEDICATIONS None See Attached

List all current prescription and over the counter medications you are taking

Medication update to be completed by therapist if changes occur:

	Date	Therapist Initials
<hr/>		
<hr/>	Date	Therapist Initials

SURGERIES OR OTHER SIGNIFICANT INJURIES None See Attached

List all past surgeries or significant injuries:

Update to be completed by therapist if changes occur:

	Date	Therapist Initials
<hr/>		
<hr/>	Date	Therapist Initials

Changes in Medical Diagnosis/Condition (Therapist: document any changes below)

	Date	Therapist Initials
<hr/>		
<hr/>	Date	Therapist Initials
<hr/>	Date	Therapist Initials