MERCY MEMORIAL HOSPITAL SYSTEM

Rehabilitation Center

New Patient Information Sheet

PATIENT'S NAME_____**TODAY'S DATE**_____

Telephone # where it is best to reach you:_____**Can we leave a message?** ☐ **Yes** ☐ **No**

MEDICAL HISTORY (Please check if any apply to you):

☐ Arthritis
☐ Asthma
☐ ADHD/ADD
☐ Anxiety/Depression
☐ Bipolar
☐ Broken Bones/Fracture
☐ Circulatory/Vascular problems
☐ Cancer
☐ *Diabetes*/ High blood sugar
☐ Dizziness
☐ Headaches
☐ Head trauma
☐ Hearing loss/Hearing aid ☐R ☐L
☐ *Heart problems*

☐ Hepatitis
☐ High/Low blood pressure
☐ Hypoglycemia/low blood sugar
☐ Infectious disease (e.g. MRSA, tuberculosis)
☐ Kidney problems
☐ Lung problems
☐ Lymphedema
☐ Mastectomy/lumpectomy
☐ Neurological disorder
☐ Osteoporosis
☐ *Pregnant or recently pregnant*
☐ *Currently breast feeding*
☐ Pacemaker

☐ Respiratory (breathing) problems
☐ Seizure disorder
☐ Skin disease
☐ Stroke/TIA
☐ Thyroid problems
☐ Ulcers/stomach problems
☐ Vision (glasses/contacts/ cataracts)

Pediatric Clients:

☐ Chicken pox
☐ Chronic ear infections
☐ Convulsions / seizures

☐ Fevers
☐ Measles
☐ Pneumonia

☐ Rheumatic fever
☐ Scarlet fever

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

☐ Chest pain
☐ Heart palpitations
☐ Persistent cough
☐ Hoarseness
☐ Shortness of breath
☐ Dizziness or blackouts
☐ Vision problems
☐ Headaches
☐ Hearing problems

☐ Coordination problems
☐ Weakness in arms or legs
☐ Loss of balance
☐ Difficulty walking
☐ Joint pain or swelling
☐ Pain at night
☐ Difficulty sleeping
☐ Loss of appetite
☐ Nausea/vomiting

☐ Fevers/chills/sweats
☐ Recent memory changes
☐ Difficulty swallowing
☐ Bowel problems
☐ Urinary problems
☐ Weight loss/gain
☐ Other _____

Have you discussed these symptoms with your physician? ☐ **Yes** ☐ **No**

Therapist use only: I have advised the patient to contact his/her physician for symptoms if indicated, checked by the patient in question # 2.
Therapist initials:

Please check any diagnostic test you have had for the <u>current</u> injury:

☐ Bone scan
☐ CT scan
☐ Doppler Ultrasound

☐ EMG
☐ MRI
☐ X-ray

☐ Other_____

Medical/surgical history: _____

_____

_____

MERCY MEMORIAL HOSPITAL SYSTEM

Rehabilitation Center

New Patient Information Sheet

General Health: (please circle response)

Excellent / Good / Fair / Poor Height_____/ Weight_____ Dominant hand:_____Right / Left

Do you currently smoke tobacco?___Yes / No Do you currently consume alcohol?_____Yes / No

Home Environment: (please circle response)

How many steps to enter your home?_____ Are there hand railings?_____Yes / No

How many levels inside your home?_____ Basement steps?_____Yes / No

Prior to your injury were you able to go up and down steps without difficulty?_____Yes / Yes, with hand railing / No

Is there anyone at home that is able to assist you if necessary? No / Yes _____

Work History:

Job title / Occupation:_____Status: ☐ Full/part-time ☐ Retired ☐ Unemployed ☐ Student

Work duties: ☐ heavy/repetitive lifting ☐ bending/squatting ☐ climbing ☐ standing/walking ☐ prolonged sitting

Are you currently off work due to this injury: ☐ Yes ☐ No Last date worked:_____

Return to work:_____

Social History:

How many times have you fallen within the past 6 months?

Were there any injuries as a result of your fall(s)? ☐ Yes ☐ No

Do you exercise beyond your normal daily activities and chores? ☐ Yes ☐ No

If yes, please describe exercises:_____

Have you been told by your physician not to drive? ☐ No ☐ Yes _____

Do you have any financial barriers or cultural beliefs that might affect your care?

☐ No ☐ Yes Explain:_____

What is the easiest way for you to learn? ☐ Personal instruction ☐ Written instruction ☐ Demonstration

Are there any relatives, friends, or caregivers that we also should be teaching? ☐ No ☐ Yes Explain:_____

THE INFORMATION I HAVE PROVIDED IS THOUGHT TO BE ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: XX_____**Date**_____

Relationship to patient: ☐ Self ☐ Family member ☐ Other _____

I HAVE REVIEWED THE ABOVE INFORMATION WITH THE PATIENT.

THERAPIST SIGNATURE: XX_____**Date**_____

MERCY MEMORIAL HOSPITAL SYSTEM
Rehabilitation Center

New Patient Information Sheet

Medication / Allergy List

PATIENT NAME: _____**Date**_____

CURRENT MEDICATIONS:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES:

_____ _____
_____ _____
_____ _____
_____ _____

ADDITIONAL MEDICATIONS (DATE): (to be completed and initialed by clinician at later date if necessary)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

THIS INFORMATION I HAVE PROVIDED IS THOUGHT TO BE ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: **XX**_____Date_____

Relationship to patient: ☐ Self ☐ Family member ☐ Other_____

THERAPIST SIGNATURE: XX_____Date_____