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)

<u>Pediatric Clients:</u>

☐ 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 _________________

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:

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

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: ____

____

____

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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:

Any major life changes during the past year? (e.g. new baby, job change, death of a family member) ☐ 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 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:______________

Would you like educational information relating to any of your medical conditions? ☐ No ☐ Yes

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__________________________

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_________________________