

Name: _____ Day Time Phone: _____

Cell Phone: _____ Age: _____ Height: _____ Weight: _____

Medical Diagnosis: _____

Present complaint & cause of injury: _____

Condition prior to incident/onset: _____

Date of symptoms onset and/or date of surgery: _____

Has your problem changed since onset: _____

Have you received outpatient PT, OT, or Speech Therapy services this past year? Y N

If so, by whom and where? _____

Are you being seen in home health at this time? Y N _____

Current medications (Please submit list of meds if available): _____

List allergies: _____

Do you smoke cigarettes? Y N

HISTORY

Have you ever had any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pregnant at this time |
| <input type="checkbox"/> Asthma/bronchitis/
emphysema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bowel/Bladder Changes | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Cancer/Type: _____ | <input type="checkbox"/> Hernia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High BP | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> HIV | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Diabetics | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Other (please list) _____ | | |

List any surgeries with dates: _____

OBJECTIVES

Primary reason for attending therapy: (choose all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Unable to work | <input type="checkbox"/> Activity Reduction | <input type="checkbox"/> Limited motion |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Loss of independence | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Unable to do household tasks | <input type="checkbox"/> Frequent Falls/decreased balance | |
| <input type="checkbox"/> Unable to play sports or recreational activities | | |

Please turn page over and complete the other side

What are your personal goals for therapy: (choose 4 that are most important)

- | | | |
|--|--|--|
| <input type="checkbox"/> Decrease pain | <input type="checkbox"/> Increase strength | <input type="checkbox"/> Improve sleep |
| <input type="checkbox"/> Increase sitting tolerance | <input type="checkbox"/> Improve posture | <input type="checkbox"/> Gain/lose weight |
| <input type="checkbox"/> Increase standing tolerance | <input type="checkbox"/> Increase mobility | <input type="checkbox"/> Return to work activities |
| <input type="checkbox"/> Resume/Improve Fitness | <input type="checkbox"/> Increase walking distance and speed | |

Pain ranking (0-10) at its worst? _____ at its best? _____

Is the pain better any time of day? _____

Is the pain worse any particular time to the day? _____

What in particular makes your pain worse? _____

What, if anything, eases your pain? _____

What else have you tried to improve your function/decrease your pain? _____

Occupation: _____

Current work status Full duty Light duty Not working

Living Arrangement: Alone Spouse/significant other Other family &/or friends

Routine activities you need to perform at work/home? _____

Exercise Program (list activities you do to maintain/improve your fitness level):

For speech and/or language problems, please answer the following:

Describe your speech and/or language problem: _____

What is your primary language and method of communication: _____

Are there any other speech-language, learning, or hearing problems in your family? Y N

If yes, describe: _____

Do you have any eating/swallowing difficulties? Y N If yes, describe: _____

Please provide any information that may be helpful in the evaluation process:

Because we believe our patients must take an active role in their rehabilitation, it is the policy of Ransom Memorial Hospital Rehabilitation Services that when a patient misses three (3) consecutive sessions for any reason, or after the second (2) no show, the patient is discharged from Rehabilitation Services. If this occurs, the patient must see their physician to get a new prescription to resume therapy.

The Ransom Memorial Hospital Rehabilitation Services Department requests that it be notified at least 24 hours in advance of any patient cancellation. This allows us sufficient time to notify other patients of the open appointment time. Any cancellation of a scheduled appointment less than 24 hours or missed appointment without notification of the clinic will be charge of \$25.

I hereby certify that I have read and accurately completed the above intake form to the best of my knowledge.

Patient Signature: _____ Date: _____