Bacharach INSTITUTE FOR REHABILITATION

MEDICAL HISTORY FORM

Patient Name: _____

Account #: _____

Patient Identification

Eval. Date: _____ DOB: _____

Diagnosis: _____

HISTORY OF CURRENT PROBLEM

The condition you are starting or continuing therapy for was a result of:

- ☐ Vehicle Accident
- ☐ Fall
- ☐ Athletic Activity
- ☐ Lifting/Carrying
- ☐ Repetitive Motion/Overuse
- ☐ Sustained position
- ☐ Gradual Onset
- ☐ Sudden Onset/No Trauma
- ☐ Pulling/pushing/climbing
- ☐ Assault
- ☐ Other_____

1. When did the problem(s) begin? Date ___/____/____
2. Have you ever had this problem/injury before?
   ☐ Yes ☐ No (go to Question # 6)
3. What did you do for the problem/injury?_____
   _____
4. Did the problem/injury get better? ☐ Yes ☐ No
5. About how long did the problem last? _____
6. What are you doing now to improve your problem/injury?
   _____
7. Have you received any therapy this calendar year?
   ☐ Yes ☐ No
   Where? _____
   How many visits? PT ____ OT ____ Speech ____
8. What are your goals for therapy?
   _____

CURRENT LIMITATIONS: (Check all that apply)

- ☐ Bed Mobility (change position in bed)
- ☐ Transfers such as moving bed to chair, chair to commode
- ☐ Walking on ☐ level surfaces ☐ stairs ☐ ramps
- ☐ uneven terrain
- ☐ Difficulty with self-care (bathing, dressing, eating, toileting)
- ☐ Difficulty with home management (chores, shopping, etc.)
- ☐ Difficulty with community and work activities
- ☐ Out of work/school☐ No participation in recreation/leisure activities
- ☐ Lifting ☐ Communication Problem

Within the past year, have you had any of the following symptoms? (Check all that apply) ☐ None

- ☐ Back/Neck Pain
- ☐ Bowel Problems
- ☐ Chest Pain
- ☐ Coordination Problem
- ☐ Cough
- ☐ Communication problem
- ☐ Difficulty Sleeping
- ☐ Difficulty Swallowing
- ☐ Difficulty Walking
- ☐ Dizziness/Blackouts
- ☐ Fever/Chills/Sweats
- ☐ Headaches
- ☐ Heart Palpitations
- ☐ Hearing Problems
- ☐ Hoarseness
- ☐ Joint Pain/Swelling
- ☐ Loss of Appetite
- ☐ Loss of Balance
- ☐ Nausea/Vomiting
- ☐ Pain at Night
- ☐ Shortness of Breath
- ☐ Urinary Problems
- ☐ Vision Problems
- ☐ Weakness/Arms/Legs
- ☐ Weight Loss/Gain
- ☐ Other _____

WHERE DO YOU LIVE?

- ☐ Private home ☐ 1-story ☐ 2-story
- ☐ Private apartment ☐1-story ☐ 2-story
- ☐ Other _____

WITH WHOM DO YOU LIVE?

- ☐ Alone ☐ Child (no spouse)
- ☐ Spouse only ☐ Other relatives
- ☐ Spouse and others ☐ Group Setting
- ☐ Personal care attendant
- ☐ Other: _____

DOES YOUR HOME HAVE

- ☐ Stairs, no railing How many? _____
- ☐ Stairs, railing How many? _____
- ☐ Steps to enter How many? _____
- ☐ Ramps ☐ Elevator ☐ Uneven terrain
- ☐ Other obstacles _____

DO YOU USE

- ☐ Cane ☐ Crutches ☐ Walker/Rollator
- ☐ Wheelchair: ☐ Manual ☐ Motorized
- ☐ Other _____

HAND DOMINANCE

☐ Left ☐ Right

FOR WOMEN: Are you pregnant, or think you might be pregnant? ☐ Yes ☐ No

FOR MEN: Have you been diagnosed with prostate disease? ☐ Yes ☐ No

HEALTH HABITS

Do you exercise beyond normal daily activities and chores? ☐ Yes ☐ No;
Type:_____
Do you currently smoke/chew tobacco? ☐ No
☐ Yes; Cigarettes/Cigars ___ # packs/day
Smoke in the past? ☐ Yes ☐ No; Years quit? _

Within the past year, have you had any of the following tests? (Check those you have had; circle test(s) you are scheduled for)

- ☐ MRI ☐ None
- ☐ Blood Tests
- ☐ X-rays
- ☐ Other

_____

MEDICAL HISTORY FORM

Patient Identification

What language are you most comfortable speaking with your therapist?

_____

Would you like an interpreter? □ Yes □ No

Bacharach can discuss my health information with the following persons who are involved in my care:

_____

_____

_____

□ None

Please check any conditions you have: □ **None**

□ Arthritis
□ Blood clots
□ Blood disorders
□ Broken bones/fracture
□ Eating Disorder
□ Circulation/Vascular
□ Depression, Anxiety, Irritability
□ Developmental Problems
□ Emotional/,behavioral problems
□ High Blood Pressure
□ Learning Disability
□ Low Blood Sugar
□ Hepatitis
□ Kidney problems
□ Lung Problem/Asthma
□ Repeated Infections
□ Heart Problems
□ Other _____

Please check any conditions you have and if you are under the care of a health professional for the following?

___ Cancer □ Yes □ No
___ Diabetes □ Yes □ No
___ Dialysis □ Yes □ No
___ Underweight? □ Yes □ No
___ Dysphagia □ Yes □ No
___ Morbid obesity □ Yes □ No
___ Multiple sclerosis □ Yes □ No
___ Parkinson's disease □ Yes □ No
___ PPN/enteral feeding □ Yes □ No
___ Substance abuse □ Yes □ No
___ Pressure ulcers/non-healing wounds □ Yes □ No
___ HIV/AIDS □ Yes □ No

Please list your current medications and their purposes (pain relief, arthritis, etc.)**: include over the counter and natural supplements.**

MEDICATION	**PURPOSE**

Do you have a history of a resistant bacteria, such as MRSA? Or if hospitalized, did staff wear gowns and gloves each time they entered the room? □ Yes □ No

FALL RISK ASSESSMENT: Have you fallen in the past three months? □ Yes □ No

ALLERGIES □ **None**

Check if you ever had the following):

Allergies: □ Medication □ Food □ Environmental □ Latex

Please list all known allergies and adverse drug reactions(attach separate sheet if needed)

_____

Have you had surgery or significant invasive procedures? □ Yes □ No

If yes, please describe, and indicate dates:

_____ _____
_____ _____
_____ _____

Have you traveled outside the United States in the past 30 days? □ No □ Yes- please tell us where

EDUCATION/EMPLOYMENT

Highest grade completed
□ College/Technical School/Vocational School
□ College Graduate □ Advanced/Graduate Degree
Your occupation?_____
Leisure interests:_____
Method you learn best: □ Watching □ Listening
□ Doing □ Having written information

CULTURAL/RELIGIOUS: Do you have any customs, religious beliefs, or wishes that might affect care?

_____

□ None

ABUSE SCREENING

Do you have any concerns about physical, emotional, or sexual abuse? □ Yes □ No

Would you like to talk to someone about your situation? □ Yes □ No

Depression Screening Over the past 2 weeks have you felt down, depressed, hopeless? □ Yes □ No

Completed By: _____Date:_____Time:_____

Reviewed By: _____Date:_____Time: _____

Are you seeing anyone else for this problem? (check all that apply) □ Acupuncturist □ **None**
□ Cardiologist □ Orthopedist □ Chiropractor □ Osteopath □ Dentist □ Massage Therapist