

Patient Name: _____

Account #: _____

Patient Identification

Eval. Date: _____ DOB: _____

Diagnosis: _____

What language are you most comfortable speaking with your therapist? _____
Would you like an interpreter? Yes No

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 _____ | |

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

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 or leisure activities
- Lifting
- Communication Problem

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

_____ None

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

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

Have you traveled outside the United States in the past 10 days? No Yes- please tell us where _____

MEDICAL HISTORY FORM

Patient Identification

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
- 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
- ___ Underweight? Yes No

Please list your current medications and their purposes (pain relief, arthritis, etc) taken for this injury/condition:

MEDICATION	PURPOSE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List all other medications/purposes: (including over-the-counter medications, vitamins, and herbs)

- _____
- _____
- _____

Not taking any medication for this problem/injury

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 _____

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 _____

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:

- _____
- _____
- _____

HEALTH HABITS

Do you exercise beyond normal daily activities and chores? Yes No; Type: _____

Do you currently smoke/chew tobacco? Yes No

Cigarettes/Cigars ___ # packs/day

Smoke in the past? Yes No; Years quit? _____

EDUCATION/EMPLOYMENT

Highest grade completed (circle one)

1 2 3 4 5 6 7 8 9 10 11 12

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

Are you seeing anyone else for this problem? (check all that apply) Acupuncturist None

- Cardiologist Orthopedist Chiropractor Osteopath Dentist Massage Therapist
- Podiatrist Internist Rheumatologist Neurologist ENT Primary Care Doctor
- Pediatrician Obstetrician/Gynecologist Occupational Therapist Other: _____