Bacharach
INSTITUTE FOR REHABILITATION

MEDICAL HISTORY FORM SUMMARY LIST

Eval. Date: ______________ **DOB:** ______________

Diagnosis: ____________________________________

Patient Name: ________________________________

Account #: ________________________________

Patient Identification

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?
   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

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

GENERAL HEALTH

__ Excellent __ Good __ Average __ Poor

Activity/Exercise:
__ None __1-2 days/wk _3-4 days/wk _5 days/wk
Describe:_________________________________

Do you currently smoke/chew tobacco? __ No
__ Yes; Cigarettes/Cigars ___ # packs/day
Smoke in the past? __Yes __ No; Years quit? ___

Mental Health: Current level of stress:
__ High __ Medium __ Low
Current psych therapy? __ Yes __ No

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 __ X-rays __ Blood Tests
__ Other________________________________ None

Are you seeing anyone else for this problem? (check all that apply)
_ Acupuncturist
_ Occupational Therapist
_ Cardiologist
_ Orthopedist
_ Chiropractor
_ Osteopath
_ Dentist
_ Pediatrician
_ Podiatrist
_ Internist
_ Rheumatologist
_ Neurologist
_ ENT
_ Primary Care Doctor
_ Massage Therapist
_Obstetrician/Gynecologist
_ Other: ____________________ _________ __ None

MEDICAL HISTORY FORM / SUMMARY LIST

All questions must be completed by the third visit to Bacharach.

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

__ Other ______________________________

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

___ Cancer Yes No ___ HIV/AIDS 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

Please list your current medications and their purposes (pain relief, arthritis, etc):

MEDICATION	**PURPOSE**
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

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

____________________	____________________
____________________	____________________
____________________	____________________

Not taking any medication for this problem/injury ___

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 (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

COMPLETED BY: ______________________________ DATE:______________ TIME: __________

REVIEWED BY: ______________________________ DATE: ______________ TIME: __________