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
Athletic Activity
Repetitive Motion/Overuse
Gradual Onset
Pulling/pushing/climbing
Fall
Lifting/Carrying
Sustained position
Sudden Onset/No Trauma
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/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	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	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.)**: 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: _____