South Peninsula Hospital Rehabilitation

Patient Information Record/Update

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Contact Phone Numbers: Work: _____ Home: _____ Mobile: _____

Occupation and/or School: _____

Primary Care Doctor/Clinic: _____Insurance Coverage for this visit: _____

Present Injury or Illness

Please answer the following questions as fully as possible. Circle Yes or No when applicable.

1. How and when (date) did the present injury occur? _____

_____

2. Was the onset gradual? Yes No
3. Did you undergo surgery? Yes No If yes, what was the date of surgery? _____
4. How long were you hospitalized? _____
5. What type of symptoms do you have? _____
6. Have your symptoms changed since you last saw your doctor? (Explain on back) Yes No
7. Are you currently experiencing any chills, sweats or fever? Yes No
8. Are your symptoms constant or intermittent? Constant Intermittent
9. Does pain interrupt or prevent you from sleeping? Yes No
10. What is the present status of your condition compared to when it began? (Circle one)
    Better Worse No change
11. Please rate your pain on a scale from 1-10 with 1 pain free and 10 maximum pain.
    Pain level at this time _____
    Pain 1-10 at its very worst _____
12. Have you ever had anything similar before?
    ___Yes ___No
13. What are your goals for physical, occupational or speech therapy?

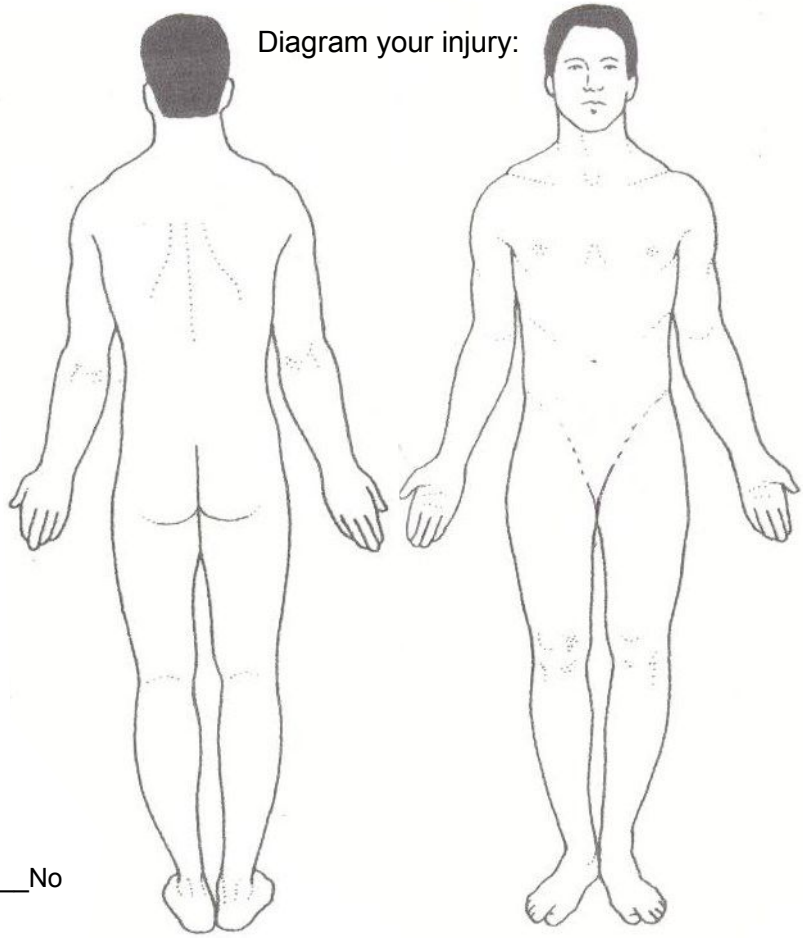
_____

_____

_____

14. At the present time, you would rate your overall general health as:
    ___excellent ___good ___fair ___poor
15. Do you smoke? ___ Yes ___ No
16. Are you currently pregnant? ___ Yes ___ No
17. Have you fallen in the past 3 months? ___Yes ___No
18. Do you walk with a walker, cane or crutches? ___Yes ___No
19. Do you have a fear of falling? ___Yes ___No
20. Do you take medication for pain or blood pressure? ___Yes ___No

Diagram your injury:



Medical History

Which activities are you having trouble performing due to your current symptoms (check all that apply)?

___Walking ___Driving (just sitting) ___Getting in/out of bed ___Getting in/out of car
___Stairs ___Caring for others ___Rising from chair/toilet ___Prolonged sitting
___Work (job) ___Dressing/bathing ___Prolonged standing ___Chores/housework

Please circle all conditions that you have, or have had in the past:

Musculoskeletal
- Osteoarthritis
- Spine Injury
- Rheumatoid Arthritis
- Headaches/ Migraines
- Fractures
- Fibromyalgia
- Osteoporosis
- Bulging Disc
- Leg Cramps/ Restless Legs
- Gout
- Other: _____

Nervous System
- Stroke/ TIA
- Polio
- Parkinson's disease
- Multiple Sclerosis
- Epilepsy/ Seizures
- Concussion/ TBI
- Numbness or Tingling
- Other:_____

Circulation/ Respiratory
- Heart Attack
- Heart Surgery
- Heart Arrhythmia
- Pacemaker
- High Cholesterol
- Blood Clots/ Phlebitis
- Anemia
- High Blood Pressure
- Bleeding Disorder
- Other: _____

Skin
- Skin Allergies/ rashes
- Eczema
- Psoriasis
- Other: _____

Infectious Disease
- TB
- Hepatitis
- Influenza
- Shingles
- Other: _____

Endocrine/Digestion
- Diabetes
- Kidney Dysfunction
- Irritable Bowel
- Bladder Dysfunction
- Liver Dysfunction
- Thyroid Dysfunction
- Hernia
- Asthma/ SOB
- COPD
- Other: _____

Cancer
- Type of Cancer _____
- Date of Diagnosis _____
- Treatments _____

Psychological
- Depression
- Anxiety disorder
- Bipolar disorder
- Schizophrenia Obsessive-compulsive disorder
- Other: _____

Surgeries: _____

Current Medications: _____

Allergies:_____

Other Conditions:_____

Have you had any other treatment for this condition (currently or in the past) **Yes** **No** If yes, please check:

___Chiropractic care ___CT scan ___Medications ___Physical therapy ___MRI ___Injections ___X-rays
___EMG/ NCV ___Other: _____

I have reviewed any contraindications and their rehabilitation protocol with the named patient or the appropriate caregiver prior to initiating evaluation and treatment.

Therapist's Signature: _____ **Date:** _____