



Rehabilitation Department
Outpatient Intake Form

Date _____
MR # _____

1. Name _____
Last First MI Jr/Sr

How do you wish to be addressed? _____

2. Preferred contact phone # _____

3. May we contact you via e-mail? Yes No

If so, please list E-mail address: _____

4. Date of birth / / 5. Male Female

6. Language: English understood? Yes No
Interpreter needed? Yes No

What language do you speak most often? _____

7. Employment:

- Employed - Occupation _____
- On disability - Occupation _____
- Unemployed Retired
- Student Not yet working age

8. Who referred you to therapy? _____

9. Have you seen anyone else for this problem?
 Yes No If yes, who? _____

10. Have you had other therapy this year?
(i.e. OT, PT, speech, psychological) Yes No

11. What is your goal for therapy?

12. What are your current activities & frequency?

13. Have you ever had surgery? Yes No
If yes, please describe & include dates: (con't on back pg if needed)

14. Medications - Do you take any non-prescription medications (check all that apply) None

<input type="checkbox"/> Advil/Motrin/Ibuprofen	<input type="checkbox"/> Aspirin/Bufferin
<input type="checkbox"/> Aleve/Naprosyn/Naproxen	<input type="checkbox"/> Decongestants
<input type="checkbox"/> Antacid	<input type="checkbox"/> Supplement/vitamin
<input type="checkbox"/> Antihistamines	<input type="checkbox"/> Tylenol
<input type="checkbox"/> Other _____	

Do you take prescription medications? Yes No
If yes, please list: _____

15. General Health Please rate your health:

- Excellent Good Fair Poor

Have you had any recent major life changes (i.e. new baby, job change, death of loved one)? Yes No

16. Have you had any of the following in the past year?

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Bone scan | <input type="checkbox"/> EKG (electrocardiogram) |
| <input type="checkbox"/> CT scan | <input type="checkbox"/> EMG (electromyography) |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> MRI |
| <input type="checkbox"/> X-rays | <input type="checkbox"/> Other _____ |

17. Are you allergic or sensitive to:

latex Yes No adhesive tape Yes No

Do you have any other significant allergies? Yes No

If yes, please list: _____

18. Medical History/THERAPY PRECAUTIONS

Please check if you've ever had, or *currently* have:

- | | |
|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> High Blood Sugar/Diabetes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Low Blood Sugar (hypoglycemia) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Heart Problems | |
| <input type="checkbox"/> Other _____ | |

Have you had any other physical problems in the past year we should be aware of? (i.e. shortness of breath, insomnia, dizziness): _____

19. Current limitations (Check all that apply)

- Difficulty with movement transfers
- Difficulty with walking: on levels on stairs
 endurance/distance on uneven surfaces
- Difficulty with self-care (i.e. bathing, dressing, eating)
- Difficulty with home management (i.e. household chores, shopping, driving/transportation)
- Difficulty during recreation or play activities

Do you need to use any of the following?

- Hand held support Cane
- Crutches Walker with / without wheels (circle)
- Stroller Wheelchair manual / power (circle)
- No devices needed for mobility

20. Where do you live?

- House Assisted living / group home
- Apartment Homeless (with or without shelter)
- Other: _____

Please describe your home situation:

- No stairs Stairs, no rail(s)
- Stairs, with rail(s) Ramps
- Elevator Uneven terrain

FOR THERAPIST USE ONLY:

SAFETY ISSUES:

- BALANCE/FALL RISK COGNITIVE HEARING
- MEMORY POSITIONAL ISSUE VISION
- OTHER: _____

Pre/Post Treatment Considerations Reviewed & Discussed with patient

Therapist Signature _____

Printed Name _____