Name:_____ DOB:_____ Gender:_____ Race:_____ Height:___ Weight:___

Occupation: Diet:

Any dietary restrictions due to health or religious reasons (please explain):
Since how long have you been following this diet:
How strictly:

Are you disabled? Please explain your disability:

Do you have any vision problems? Do you wear glasses? Do you have any hearing problems?

Do you wear hearing aids?

What brought you here?

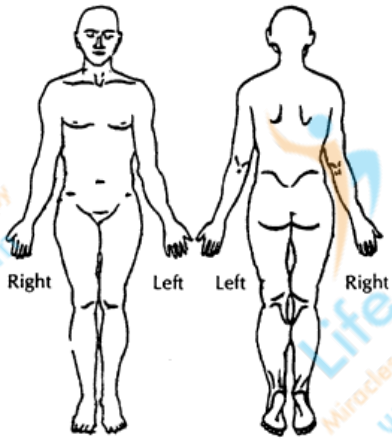
Please describe your hospitalization, length of stay, any therapy received, and your functional status/ ability to perform activities like getting in and out of bed in detail.

Pain History: Are you in any pain now?

If you don't have pain, please skip this section and go to next section.

Since how long you have this pain?

On the faces pain scale below, please describe how bad your pain is:



Please locate your pain in the body chart below.

Pain relieving factors:

Pain aggravating factors:

Answer yes or no to following questions:

Pain history	YES	NO	If yes, please explain
Did you have similar kind of pain in past?			
Is your physician aware of this pain?			
Any surgery or medication taken for the pain?			
Was there a recent injury or flare up?			
Do you have night pain?			
Is there a consistent time that you wake up due to pain?			
What do you do to go back to sleep?			

Social History:

Answer the following questions. In order to understand your daily routine and activity level, please be as specific if you can.

Questions	Answers
What did you do for living and how long?	
When did you retire?	
Are you involved in any physical activities, like gardening/exercise/ walking/ biking? How often a week?	
Does your daily activity involve prolonged sitting, standing or any other posture? How many hours/day?	
What is the main limiting factor in maintaining your daily routine for example: tired, short of breath etc...	

How would you rate your social life: Very active, active, somewhat active, not active?

Are you currently grand parenting? Are you a care giver? Are you socially involved in religious place like church or are you a community volunteer? Please explain your role.

Do you smoke? How many packs a day? Since how long have you been smoking? Have you ever tried quitting/ using alternative smoking methods? How long?

Do you drink alcohol? If yes, how many glasses per day?

Medical History: In the section below, write your diagnosis.

Surgical and hospitalization History: (include date and reason)

1.

2.

3.

4.

5.

Family History:

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for following:

	YES	NO
Diabetes		
Heart Disease		
High Blood Pressure		

Stroke		
Cancer		
Inflammatory arthritis (rheumatoid, ankylosing)		
Alcoholism (chemical dependency)		
Depression		
kidney disease		

Medications:

Prescribed:

Non-prescribed:

Any recent changes in medications (including dosage) Explain:

Please circle following that are NEW, UNUSUAL, or ATYPICAL. If you answer YES, please explain your changes, if your physician is aware of it and if you are taking any measure for it, in last row.

	YES	NO	If yes, please explain
Weight loss/ gain			
Fatigue/ tiredness			
Dizziness			
Weakness/ lethargy			
Fever/chill/sweats			
Easily bruising			
Recent change in vision (double vision, loss of visior			
Change in urination (painful urination/ frequency/urgency/ change in color of urine/difficulty in urination)			
Change in bowel movement (blood in stool, diarrhea or constipation)			
Difficulty sleeping at night			

What is your goal to achieve from physical therapy? Why do you want to achieve that goal?

Home Environment:

Our rehab department offers a home evaluation and recommends adaptive devices to facilitate maximum independence. To assist you further, please describe your home environment. You can also share pictures of your house with your physical therapist during evaluation.

Describe your role at home for daily activities like cocking, cleaning, grocery shopping etc… You can also mention if you have home health aide or a family member helping you.

Do you drive? Do you have difficulty driving especially at night? Does anyone from your family often tells you to stop driving? Do you mind if your therapist take a look at your car while your stay here with us?

Fall History: Did you fall in last 6 to 8 months? How many times? How do you usually fall (like loss of balance, dizziness, faint, legs gave out etc….)

History of behavioral health:

In past few months, have you been feeling sad, hopeless, or depressed?

Have you lost any close family member within a year? Who was he/ she? What happened?

Do you seek any medical attention for your depression?

Clinical labs & tests:

Please describe if you have any of following tests done during your most recent hospitalization. Also describe the results… Blood work: X ray: MRI: Endoscopy: Colonoscopy:

any other:

Do you have any other information that you want to share with us:

References:

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Hospice education institute. PAIN. https://www.hospiceworld.org/book/pain.htm