PATIENT LABEL

AULTMAN
THERAPY SERVICES
PATIENT INJURY/HEALTH HISTORY

Onset of Problem _____/_____/_____ Date of Surgery _____/_____/_____ Next Physician Appointment _____/_____/_____

Name_____ Diagnosis/Problem/Affected Side: ❑ R. ❑ L. ❑ N/A _____

Please explain your problem and your goals for rehabilitation: _____

_____

Are there any legal proceedings related to your condition? (i.e. lawsuits filed) ❑ No ❑ Yes: _____

❑ Yes ❑ No Are you currently playing sports/working/attending school?
If yes, please list: _____

❑ Yes ❑ No Is this problem making it difficult to care for yourself or others?
If yes, explain: _____

❑ Yes ❑ No Is this the first injury/pain to this body part?
If no, please explain: _____

❑ Yes ❑ No Are you currently receiving treatment(s) for this problem or have you received treatment for it in the past?
Please indicate X-Ray, MRI, CT Scan. If yes, please list: _____
Did it help? ☐ Yes ☐ No

❑ Yes ❑ No Have you had therapy for this same problem before? Did it help? ☐ Yes ☐ No
If yes, where did you receive it and what was done:_____

❑ Yes ❑ No Do you have any difficulty with your activities of daily life (bathing,dressing,mobility,etc.) **not related** to this problem?
If yes, please explain: _____

❑ Yes ❑ No Do you currently take any medications? ❑ Check here if you have provided a copy of your medication list.
If you did not bring a copy of your list, write them here: _____

❑ Yes ❑ No Have you had any previous surgeries?
If yes, please list: _____

❑ Yes ❑ No Are you currently receiving ANY home health care services for any reason (OT, PT, nurse, aide, Speech)?
(Please be advised that your insurance may not pay for both home and outpatient care).

❑ Yes ❑ No Have you had any PT, OT, Speech, or chiropractic care in the past year for any injury/condition?
If yes, how many visits?: _____

❑ Yes ❑ No Does your insurance limit how many therapy visits you can have?
Describe the limits: _____

PROBLEM			YEAR	PROBLEM			YEAR
Back Pain/Injury	Yes	No		Osteoporosis/Osteopenia	Yes	No	
Arthritis	Yes	No		Pacemaker	Yes	No	
Fainting or dizzy spells	Yes	No		Neurotransmitter implant	Yes	No	
Frequent headaches or migraines	Yes	No		Peripheral Vascular Disease	Yes	No	
Epilepsy/Seizures	Yes	No		Diabetes/Low blood sugar	Yes	No	
Heart failure, heart attack, other heart disease	Yes	No		Lung disease/shortness of breath	Yes	No	
High/Low blood pressure	Yes	No		Cancer ❑ Chemotherapy ❑ Radiation ❑ Surgery	Yes	No	
Stroke/Transient Ischemic Attack	Yes	No					
Neurological Disease (i.e. Parkinson's, Multiple Sclerosis)	Yes	No		Autoimmune disease (i.e. lupus)	Yes	No	
				Hernia(s):	Yes	No	
Mental Impairments Please list:	Yes	No		Kidney Failure/Disease	Yes	No	
				Any reason to believe you may be pregnant?	Yes	No	
Allergies Please list:	Yes	No		Have you smoked in the past year?	Yes	No	
				Would you like information on smoking cessation?	Yes	No	
Hospitalized for cellulitis in past 2 years?	Yes	No					
Taken antibiotics for cellulitis in past 2 years?	Yes	No		Handout issued: Staff initial:			

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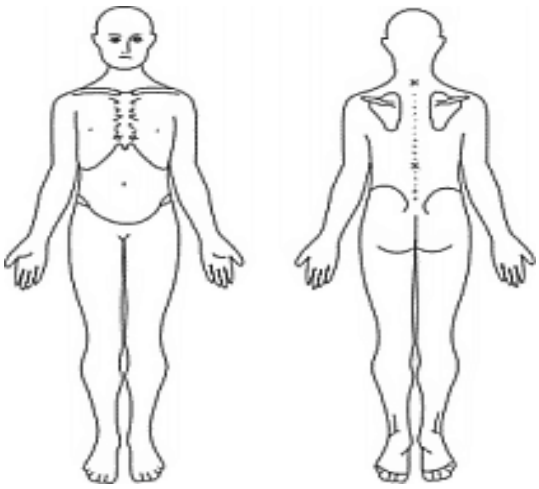
Please rate your health at the present time: Hand Dominance:
❑ Excellent ❑ Very Good ❑ Fair ❑ Poor ❑ Right ❑ Left

Please rate your pain by placing a mark (x) on the following scale:

0 1 2 3 4 5 6 7 8 9 10
No Pain Excruciating



Please shade in areas affected by pain

Describe the pain (i.e. ache, burn, throb, etc.):_____

When is the pain the worst? ❑ Morning ❑ as the day progresses ❑ Night

What increases the pain?_____

What decreases the pain?_____

What is your goal for pain (0-10)?____

If you have swelling, what makes it better? _____Worse?_____

Living situation: ❑ Living alone ❑ Lives with:_____
❑ Single level home ❑ Multi level home ❑ Must Use stairs

Check any medical equipment you own: ❑ Walker ❑ Wheel Chair ❑ Cane ❑ Crutches ❑ Elevated toilet seat ❑ Tub Bench
❑ Other:_____

Do you have any barriers to or special needs for learning?

BARRIERS

Language other than English Specify:	❑ Yes ❑ No
Difficulty reading or other learning difficulty	❑ Yes ❑ No
Visual/hearing impairment	❑ Yes ❑ No

NEEDS

Special religious or cultural need or request Specify:	❑ Yes ❑ No
Health related financial concern	❑ Yes ❑ No
In the past month have you often been bothered by feeling down, depressed or hopeless?	❑ Yes ❑ No
In the past month have you often been bothered by little interest or pleasure in doing things?	❑ Yes ❑ No
Safety concerns within your home	❑ Yes ❑ No

Learning preference:
❑ Verbal ❑ Written ❑ Demonstration

Is it acceptable to leave messages at your home or on your answering machine?
❑ No ❑ Yes With whom? _____

Are there any restrictions for disclosure of your Personal Health Information?
❑ No ❑ Yes If yes, provide restrictions: _____

Please read the following important information:

▶ Insurance coverage verification for therapy services is your responsibility. If you have questions about your coverage, please contact your insurance carrier.

▶ Cancel/No Show Policy — If you cancel more than 3 times we may discharge you from therapy. If you no show 2 times in a row or 3 times in a month we may discharge you from therapy.

▶ Do you currently have an active advance directive document (i.e. durable power of attorney or living will)? ❑ Yes ❑ No
If no, would you like information on advance directives? Information provided? ❑ No ❑ Yes _____ Initials.

▶ Should a medical emergency situation occur our staff may perform Basic Life-Saving Services (BLS), call 911, and activate the Emergency Medical System (EMS) as deemed necessary.

▶ Please refrain from wearing perfumes/colognes to therapy. They can cause breathing problems for people with certain medical conditions.

Date:_____ Time:_____ Patient Signature:_____

Date:_____ Time:_____ Therapist Signature:_____