Huntington Hospital **Outpatient Rehab**

Patient Name: _____ Date: _____

Home Street Address	**City/State/Zip Code**	**Home Phone**
Date of Birth	**Email Address**	**Cell Phone**
Emergency Contact	**Relationship**	**Contact Number**
Referring Physician	**Referring Physician Phone**	**Primary Care Physician**
Employer Name/Street Address	**City/State/Zip Code**	**Work Phone**

Primary Language: ☐ English ☐ Spanish Other: _____

If needed, is someone able to come with you to help translate? ☐ Yes ☐ No

Currently receiving any home care (Is a nurse or therapist coming to your home)? ☐ Yes ☐ No

Have you recently had any therapy services elsewhere? ☐ Yes ☐ No

If so, when and what condition(s) were you treated for: _____

Are you currently off of work due to your injury? ☐ Yes ☐ No

Reason(s) why you are here for therapy: _____

How did your injury/symptoms occur: _____

Date of your injury/surgery: _____

Other treatment(s) you have received: _____

Any tests for this condition (xray/MRI/etc): _____

List examples of limitations on daily routines: _____

Personal goal(s) for coming to therapy: _____

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I. MEDICAL HISTORY (Check the appropriate line)

		No	Yes			No	Yes
1.	Heart Attack	___	___	12.	Rheumatoid Arthritis	___	___
2.	Heart Problems	___	___	13.	Degenerative Arthritis	___	___
3.	High Blood Pressure	___	___	14.	Gout	___	___
4.	Stroke	___	___	15.	Fibromyalgia	___	___
5.	Anemia	___	___	16.	Seizures	___	___
6.	Asthma	___	___	17.	Osteoporosis	___	___
7.	Emphysema	___	___	18.	Kidney disease	___	___
8.	Tuberculosis	___	___	19.	Cancer	___	___
9.	Depression	___	___	20.	GI Disorder	___	___
10.	Diabetes	___	___	21.	Bowel/bladder problems	___	___
11.	Multiple Sclerosis	___	___	22.	Pregnant (women only)	___	___

23. Other illnesses diagnosed by a physician: _____

_____

II. SURGICAL/PROCEDURE HISTORY (Have you had any type of surgery or procedure?)

Surgery/Procedure	Date	Surgery/Procedure	Date
_____		_____	
_____		_____	

III. CURRENT MEDICATIONS

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. ALLERGIES

_____	_____	_____

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V. QUESTIONS RELATED TO YOUR SAFETY

1. Is anyone not allowing you to obtain healthcare? ☐ Yes ☐ No
2. Is anyone using your money, food, or housing against your wishes? ☐ Yes ☐ No
3. Is any relationship causing you fear, emotional, or physical harm? ☐ Yes ☐ No
4. Do you have any thoughts about harming yourself or others? ☐ Yes ☐ No
5. Have you had any recent falls (within the last 1-2 months)? ☐ Yes ☐ No

VI. OTHER - Is there any other information that you think we should know?

____

____

Thank you!

FOR REHAB PERSONNEL ONLY

Any need for interpreter or use of AT&T interpreter line?	☐ Yes	☐ No	___________
Any barriers to learning identified (reading, writing, comprehension)?	☐ Yes	☐ No	___________
Has patient received patient safety brochure ("12 things…")?	☐ Yes	☐ No	___________
Brochure reviewed with patient and patient understands?	☐ Yes	☐ No	___________
Reviewed insurance parameters with patient?	☐ Yes	☐ No	___________

Reviewed by: ____ **Date:** __________________________