Memorial HOSPITAL

Name: _____ **Date of Birth:** _____ **Date:**_____

1. Cultural/ Religious: Any customs or religious beliefs or wishes that might affect your care?

_____

2. In the event of an emergency, who would you like us to contact:
Name:_____ Relationship _____ Phone Number: _____

3. Have you completed any of the following advance directives?
Do Not Resuscitate □ Yes □ No
Living Will □ Yes □ No
If yes, do you wish to provide us a copy of your advance directive? □ Yes □ No
Do you want a referral to learn more about advance directives? □ Yes □ No

4. Is this a work related injury? □ Yes □ No

5. Employment/ Work: Occupation:_____ _____
□ Working full time □ Working part time □ Unemployed □ Retired □ Student □ Homemaker

6. General Health Status: Please rate you health: □ Excellent □ Good □ Fair □ Poor
Have you had any major life changes during the past year? □ Yes □ No (i.e., new baby, job change, death of loved one)

7. Medical/ Surgical History:

a. Check if you have had or currently have:

□ Pacemaker	□ Blood Disorders	□ Thyroid Problems	□ Arthritis: Rheumatoid or Osteoarthritis (circle)
□ COPD	□ Depression	□ High Blood Pressure	□ Stroke
□ Diabetes	□ Broken bones Fractures	□ Osteoporosis	□ Seizures/ Epilepsy
□ Allergies	□ Heart Problems	□ Cancer	□ Infectious Disease (e.i., tuberculosis, hepatitis)
□ Head Injury	□ Circulation Problems	□ Parkinson's Disease	□ Lung Problems

□ Other:_____

b. Have you had any of these symptoms within the last 6 months? (Check all that apply)

□ Chest Pains	□ Bowel or bladder control problems
□ Pain at Night	□ Calf pain or swelling
□ Fever/ Chills/ Sweats	□ Unexplained weight loss/ gain
□ Dizziness or Blackouts	□ Unexplained weakness in arms/ legs

□ Radicular symptoms (numbness, tingling, shooting pain in (L) arm (R) arm (L) leg (R) leg)
□ Other:_____

Patient ID

c. Have you ever had surgery? □ Yes □ No If yes, please describe, and include dates:

Surgery	Month/ Year	Surgery	Month/ Year
_____	/	_____	/
_____	/	_____	/

For Women only: Are you pregnant, or think you might be pregnant? □ Yes □ No

8. Pain – Please rate your current best and worst pain levels within the last 2 weeks on our scale of 0-10 (0 = no pain at all, 10 = is pain so bad you would go to the emergency room)
Current pain level ____ **Best pain level** ____ **Worst pain level** ____

9. Current Function – Please rate how you are functioning with your normal daily activities on our scale from 0-100% (0% = unable to get out of bed, 100% = how you functioned before your injury or problems began)
Current Function Level (0-100%) _____

10. Current Condition(s)/ Chief Complaint(s)

a. Describe the problem(s) for which you seek therapy.
_____

b. What happened? Describe the injury: _____

c. When did the problem(s) begin (date)? _____

d. Have you ever had the problem(s) before? □ Yes □ No **If yes**,
(a) what did you do for the problem? _____
(b) Did the problem(s) get better? □ Yes □ No
(c) How long did the problem(s) last? _____

e. What are your goals for physical/ occupational therapy?
_____

11. Please list your current Medications:

12. Do you have any allergies? □ Yes □ No If yes, please list allergies below:

_____

_____

Signature _____ Date: _____

If filled out by someone other than the patient: Relationship to patient:_____

Patient ID

REHABILITATION SERVICES HEALTH HISTORY