



Please bring this completed form to your first appointment.
For Riverfront clients only, you may email your completed form to
RiverfrontAdmissions@MageeRehab.org.

Email Address: _____

OUTPATIENT THERAPY NETWORK

Date: _____

Initial Patient Intake Form

Name: _____ DOB: _____ MR#: _____

Diagnosis: _____ Physician Name: _____

HISTORY OF CURRENT PROBLEM

- What is the problem?

- What is the onset date for the problem (mm/dd/yyyy)?

- What caused the problem?

- What makes the problem better/worse?

- Have you had any prior treatment for this problem/condition?

- Have you had this problem/condition before? YES NO
 - If YES, Did you get better?: YES NO SOMEWHAT

MEDICAL HISTORY

Do you have an out of hospital **DO NOT RESUSCITATE ORDER** or **POLST form**? Y N

If yes, please provide a copy. Copy provided? YES NO Date received _____.

Do you have any **INTERNAL STIMULATORS**? (Please circle **ALL** that apply):

PACEMAKER INTERNAL DEFIBRILLATOR DEEP BRAIN STIMULATOR

Have you ever been diagnosed with or treated for the following (hospitalization included)?

PLEASE CHECK ALL THAT APPLY

	YES	DATE
Alcohol Abuse		
Anemia		
Arthritis/ Rheumatism/ Gout		
Asthma		
Bleeding Tendency		
Bowel Disorder/ Colitis		

	YES	DATE
Gall Bladder Disease		
Head Injury/Loss of Consciousness		
Heart Problems or Increased Cholesterol		
High Blood Pressure		
Hepatitis		
Kidney, Bladder,		

PATIENT NAME: _____ **MR#:** _____

			Prostate Problems		
Cancer/ Tumors			Nervous/Emotional Problems		
Depression			Osteoporosis		
Diabetes			Phlebitis		
Drug Abuse			Stomach Problems/ Ulcers		
Emphysema/Bronchitis			Stroke		
Epilepsy/Seizures			Tuberculosis		
Falls/Loss of Balance			Other:		

Have you had surgery for any reason including any of the above conditions? YES NO
 If YES, please list and include dates:

Have you had any of the following within the past year? (Please circle ALL that apply)

- | | |
|------------------------|---------------------|
| Bowel/Bladder problems | Hearing problems |
| Chest pain | Heart palpations |
| Coordination problems | Hoarseness |
| Cough | Joint pain swelling |
| Difficulty sleeping | Loss of appetite |
| Difficulty swallowing | Nausea/ vomiting |
| Dizziness/ blackouts | Night pain |
| Falls/ Balance problem | Shortness of breath |
| Fever/ chills/ sweat | Urinary problems |
| Headaches | Vision problems |

Other: _____

**Please EXPLAIN any circled items:

Have you had any weight gain/loss (> 10 pounds) in the past month? YES NO
 If YES, how much? _____ Pounds Current height _____ Weight _____

Medications:

Do you have any known adverse and allergic drug reactions: YES NO
 If YES, List: _____

PATIENT NAME: _____ MR#: _____

Please list ALL current medications and prescribing physician:

Prescription medications: _____

Non prescription medications: _____

Vitamins/ minerals/supplements: _____

The following questions ask about your PAIN:

PAIN SCALE: 0 (no pain) <----->10 (worst pain)

My CURRENT pain is rated as: _____ Location: _____

At WORST, my pain is 0 – 10: _____ At BEST, my pain is 0 – 10: _____

Pain/Current Condition limits which of the following?

(Please circle ALL that apply)

Movement Walking (at home, level ground, uneven ground, ramps, curbs, stairs)

Standing Sitting Self Care (Bathing, Dressing, Eating, and Toileting)

Lifting Home Management (Cleaning, Shopping, Chores)

Bending Getting In and Out of Bed

Driving Work activities

Leisure activities

Other: _____

SOCIAL HISTORY

Health Habits:

Do you smoke? YES NO # _____ Packs per day Quit (Year) _____

How many days do you exercise in an average week? _____

How long is your average exercise session? _____

Describe the exercise: _____

Employment:

(Please circle ALL that apply)

Full time Part time Unemployed Retired

Inside home Disability Student

Occupation: _____

PATIENT NAME: _____ MR#: _____

If you are not currently working, do you plan to return to work? YES NO
Are you interested in changing jobs? YES NO

Home Set-Up:

Please Circle: 1-Story Home Multi-Story Home Apartment Other: _____

steps to enter: _____ with right rail/ left rail ramp elevator

steps to go upstairs: _____ with right rail/ left rail stair glide elevator

steps to go to basement: _____ with right rail/ left rail stair glide elevator

Do you have a 1st floor set-up (Bed and Bathroom)? YES NO

Who do you live with? (Please circle ALL that apply)

Alone Parent Spouse Children Significant other

Parent (please specify): _____

Other (please specify): _____

Do you have any attendant care? YES NO Hours/day _____ Days/week _____

Do you have/use any medical equipment? (Please circle ALL that apply)

Cane Walker (without wheels) Quad Cane

Crutches Walker (with wheels) Bracing

Orthotics Prosthesis Electric Stimulation

Shower Chair Devices Manual Wheelchair

Commode Power Wheelchair

Other: _____

Cultural/ Religious:

Do you have any customs or religious beliefs that may affect care? YES NO

List 4 goals for therapy:

- 1.
- 2.
- 3.
- 4.

PATIENT NAME: _____ MR#: _____

Do you have any other concerns or needs that we can be of assistance with?

REGISTRATION STAFF USE ONLY

Discussed Cancellation/No-Show Policy with patient?

Please circle: YES NO

Discussed Patient Health Profile with patient?

Please circle: YES NO

Patient's initials: _____

Registration Staff initials: _____

CLINICIAN STAFF USE ONLY

1. Patient understands and can apply basic information:

YES NO SOMEWHAT (Requires reinforcement)

2. Learning readiness of patient: Ready Not Ready No Interest Declines

3. Learning barriers: None Vision Hearing Language → Interpreter Needed

Unable to Read/ Comprehend What is Read

Other: _____

4. How does patient best learn? Pictures Reading Listening Demonstration

Other: _____

Therapist's signature(s) _____ Date: _____ Time: _____

_____ Date: _____ Time: _____