Print Form

Main Line Health Outpatient Rehab Network
INTAKE ASSESSMENT FORM

Patient Name: _____ Medical Record #: _____

CHIEF COMPLAINT: (Reason for attending therapy) _____

Are you currently receiving therapy, including Home care service (ie: Home Health Nurse, Home Therapy) elsewhere?
No ____☐____ Yes ____☐____ (explain) _____

Have you received services for this condition in the past? No ____☐____ Yes ____☐____ (explain) _____

How did you hear about this facility? ☐Doctor, ☐Insurance, ☐Friend/Family, ☐Internet/Ad/TV, ☐Other _____

If you are interested in hearing about our free community education seminars, please provide your email address as well as any specific topics/areas of interest: _____

MEDICAL PROBLEMS: ***(PLEASE CHECK MARK ONLY THOSE WHICH APPLY)***

CARDIOVASCULAR		***ORTHOPEDIC***
☐**No Identified Problem**	☐Varicose veins	☐**No Identified Problem**
☐Hypertension (High BP)	☐Pacemaker/Defibrillator/Both	☐Joint replacements_____
☐Hypotension (Low BP)	☐Circulation Problems	☐Metal Implants
☐Heart attack	☐Pain in calves when walking	☐Osteoporosis
☐Chest Pain / Angina	☐Blood clots / Phlebitis	☐Amputation
☐Irregular rhythm or murmur	☐Aneurysm	☐Fractures/broken bones
☐Congestive Heart Failure	☐Blood / Bleeding Disorder	☐Spinal Problems
☐Other _____	☐Other _____	☐Arthritis ☐Rheumatoid ☐ Osteo
☐Other _____	☐Other _____	☐Other: _____

NEUROLOGIC		***PULMONARY***
☐**No Identified Problem**	☐Epilepsy/seizures	☐**No Identified Problem**
☐Migraine	☐Stroke (CVA) or TIA	☐Asthma / Bronchitis
☐Loss of consciousness	☐Head injury/concussion	☐Emphysema/COPD
☐Balance problems or vertigo or any falls in last 2 years	☐Memory Loss	☐Asbestosis
	☐Confusion	☐Shortness of Breath
☐Fainting / Blackouts	☐Spinal Cord Injury	☐Tuberculosis (TB)
☐Parkinson's Disease	☐Multiple Sclerosis (MS)	☐Pneumonia
☐ALS (Lou Gehrig's Disease)	☐Coordination Problems	☐Snoring / Sleep Apnea
☐Rheumatic fever	☐Dizziness	☐Breathing Devices
☐Weakness in arms or legs	☐Aphasia/ Speech problems	☐Dysphasia / Swallowing prob.
☐Polio / Post Polio Syndrome	☐Other _____	☐Other _____

METABOLIC	***GASTROINTESTINAL***	
☐**No Identified Problem**	☐**No Identified Problem**	☐Gall Bladder Dx
☐Diabetes ☐Insulin Dependent ☐Oral Meds ☐Diet Controlled	☐Hepatitis ☐A ☐B ☐C	☐Irritable Bowel Syndrome
	☐Ulcers	☐Nausea / Vomiting
Blood sugar ☐High ☐Low	☐Hiatal Hernia / Reflux	☐Diverticulitis
☐Thyroid Problems ☐Hyper ☐Hypo	☐Weight Change ☐ Gained _____ ☐ Lost _____	☐Crohn's / Colitis
		☐Other _____

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GENITOURINARY	***PSYCHOLOGICAL***	***GENERAL MEDICAL***
☐**No Identified Problem**	☐**No Identified Problem**	☐**No Identified Problem**
☐Kidney Stones	☐Alcohol Use. Drinks/day____	☐Glaucoma / Cataracts
☐Prostrate Problems	☐Drug Use _____	☐Visual Problems
☐Burning/ Urgency /Frequency	☐Tobacco Use _____	☐Skin Problems
☐Blood In Urine (Hematuria)	☐Depression	☐Hearing Deficit / Hearing Aide
☐Kidney Failure	☐Panic / Anxiety Attacks	☐Cancer: _____
☐Dialysis	☐Claustrophobia	☐Night Pain
☐OB / Gyn Difficulties	☐ADD / ADHD	☐Infectious Dz
_____	☐Mental Retardation	☐Sexually Transmitted Dz
☐Other _____	☐Physical / Psychological Abuse	☐Other _____

ALLERGIES (seasonal, medication, skin, cold, latex, perfume, tape/band-aid, others)**:**

_____

_____

Patient's Emergency Contact: _____ **Phone #:** _____

Relationship to Patient: _____ **Alt. Phone #** _____

CURRENT / PAST SURGICAL HISTORY:

1)	6)
2)	7)
3)	8)
4)	9)
5)	10)

MEDICATION	**CONDITION**	**DOSAGE**	**FREQUENCY**	**DC DATE**
1)				F
2)				I B
3)				L Y
4)				L
5)				E S
6)				D T
7)				A
8)				F
9)				O F
10)				U
**** Attach medication sheets if available ****				T

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Have you had any of the following tests done in the past year? If yes please check test and list month and year as able.

Test	*Date*	*Test*	*Date*
☐ Angiogram		☐ Pulmonary Function	
☐ Arthroscopy		☐ Spinal tap	
☐ Biopsy		☐ Stool test	
☐ Blood test		☐ Stress test (treadmill)	
☐ Bronchoscopy		☐ Stress test (bike)	
☐ Dexascan		☐ Urine test	
☐ CT Scan		☐ Cystoscopy	
☐ Doppler ultrasound		☐ Uroflowometry	
☐ EKG		☐ X-ray's arm	
☐ EEG		☐ hand	
☐ EMG		☐ leg	
☐ Mammogram		☐ foot	
☐ Myelogram		☐ spine	
☐ MRI		☐ Upper Endoscopy	
☐ Pap Smear		☐ Lower Endoscopy	
☐ VFSS		☐ Other	

Please check the activities that you are unable to do or are difficult to perform:

☐ Sitting	☐ Lifting objects	☐ Bathing/toileting
☐ Standing	☐ Grasping objects	☐ Comb/wash hair
☐ Walking	☐ Overhead reaching	☐ Dressing
☐ Bending	☐ Household chores	☐ Fastening bra
☐ Turning head	☐ Shopping	☐ Putting shirts on/off
☐ Getting out of chair	☐ Driving	☐ Tying shoe
☐ Steps	☐ Eating	☐ Slipping on shoes
☐ Swallowing	☐ Talking	☐ Putting pants on/off
☐ Reading	☐ Writing	☐ Buttoning shirt/pant
☐ Communicating	☐ Other: _____	☐ Other: _____

☐ What is your current Diet:	
☐ Do you use augmentative communication?	Device?

Patient Signature_____ **Date** _____