Vanderbilt Rehabilitation Center
of Newport Hospital
A Lifespan Affiliate

Name:_____ Date of Birth:_____

Home phone: _____Cell phone:_____

Medical Record Number:_____

Outpatient Rehab History Intake

CHIEF COMPLAINT

When did the problem begin? _____

Describe the problem/current complaint for which you seek therapy:

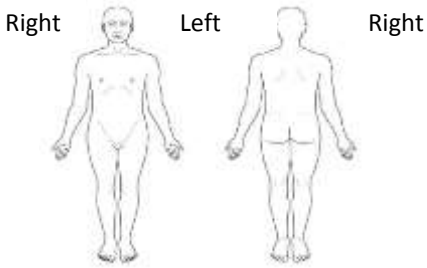
_____

What are your personal goals for therapy? _____

Have you required rehabilitation services in the past year? ☐yes ☐no If yes, when? _____

PAIN/FUNCTIONAL COMPLAINTS

If **pain** is one of your symptoms, please mark the location of the pain.



Please rate your pain (0 = no pain, 10 = worst pain imaginable) over the past 24 hours: At best: ____ At worst: ____ Presently: _____

FUNCTION

Please describe any problems/difficulty in the following areas as they relate to the condition for which you are seeking treatment.

Daily Life Difficulties: _____

Work Difficulties:_____

MEDICAL HISTORY

Are you pregnant? ☐yes ☐no If so, when is your due date?_____

MEDICAL HISTORY - Have you been diagnosed with any of the following conditions (please check any that apply)

☐ Arthritis	☐Head injury	☐Infectious disease	☐Thyroid problems
☐ Asthma	☐Headaches	☐Kidney problems	☐Vision impairment
☐ Broken bones/fractures	☐Heart attack	☐Liver disease	☐OB/GYN problems
☐ Cancer	☐Heart disease	☐Low blood pressure	☐Neurological problems
☐ Circulation/vascular problems	☐Hearing impairment	☐Lung problems	☐Osteoporosis or Osteopenia
☐Depression or Anxiety	☐High cholesterol	☐Obesity	☐No Medical Problems
☐Diabetes	☐Incontinence	☐Psychiatric Disorders	☐Other
☐Fibromyalgia	☐ High blood pressure	☐Seizures/epilepsy	☐Other

SURGICAL HISTORY

Have you had a recent/related surgery? ☐yes ☐no. If yes, please list type of surgery and date:

_____

CLINICAL TESTING:

Within the last year have you had any tests (x-rays, MRI, etc.)? ☐yes ☐no If yes, please list:

_____

Prescription medications
List all the brand-name and generic prescription medications you currently take.

Non-prescription medications, vitamins and supplements
List all those you take occasionally, as well as those you take every day.

Have you ever had an *allergy*? ☐yes ☐no. If yes, please list. _____

Health Status/Living Environment/Social Support:

Do you currently use tobacco? ☐yes ☐no

Are you working? ☐Full time ☐Part time ☐Unemployed ☐Homemaker ☐Student ☐Disabled ☐ Retired

Please list your occupation (or previous occupation if retired) _____

Health Status/Living Environment/Social Support - LIVING ENVIRONMENT:

Where do you live? ☐Private home ☐Private apartment ☐Assisted Living ☐other

With whom do you live? _____

Is there a family member/friend available to assist your with chores/shopping/bathing/transportation? Yes__No__

Does your home have?

☐any obstacles ☐elevator ☐ramps ☐stairs with railing ☐stairs without railing ☐uneven terrain ☐other

Health Status/Living Environment/Social Support - EQUIPMENT

Do you use an assistive device or equipment for walking, bathing, dressing, home safety, breathing, or any braces/prosthesis? ☐yes ☐no If yes, what device: _____

SYSTEMS REVIEW

How do you learn best (check all that apply)? ☐Demonstration ☐Written ☐Verbal

BALANCE/FALLS

Have you fallen within the past year? ☐yes ☐no

CONTRAINDICATIONS/PRECAUTIONS

Any medical restrictions/precautions? ☐yes ☐no

LANGUAGE

What is your preferred language for healthcare discussion: _____Interpreter services needed? ☐yes ☐no

I authorize the therapist/therapist assistant on staff at The Rhode Island Hospital Outpatient Rehab Dept. to treat my present illness/injury. I fully consent to participate in treatment, whether it is on or off hospital grounds. I acknowledge that I am responsible to keep my schedule visits to maximize the benefit from therapy.

Client Signature_____ **Date** _____**Time**_____

Client is a minor _____ years of age. Client is unable to complete the form or sign because:_____

Authorized representative signature Date/Time

___ I have reviewed the above information. ____ I witnessed the client or authorized representative signature.

Therapist signature: _____ Date: _____ Time: _____