SPAULDING™
REHABILITATION HOSPITAL
CAPE COD

PATIENT IDENTIFICATION AREA

OUTPATIENT SERVICES
PATIENT GENERAL HEALTH INFORMATION

PATIENT NAME: _____

DIAGNOSIS: _____ **AGE:** _____

REFERRING M.D.: _____

What condition brings you to therapy (in your own words): _____

_____

Have you been hospitalized for this condition? Yes _____ No _____ When: _____

_____

How long have you had this condition? _____

Please list all injuries, accidents and/or bad falls related to your current condition: _____

_____

Are you currently working? Yes _____ No _____

What is/was your occupation? _____

Please list medications you are currently taking (include over the counter medications): _____

_____

_____

_____

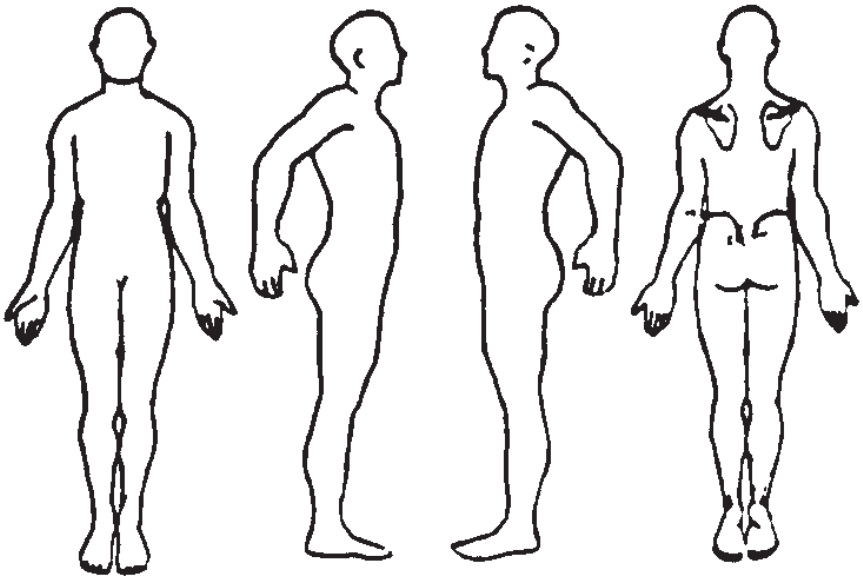
Do you have any drug allergies? _____

Do you currently (circle yes or no):

Smoke YES NO Amount: _____

Drink Alcohol YES NO Amount: _____

Please indicate the areas of pain by placing an "X" on the picture below.



(0=No Pain to 10=Unbearable Pain)

Rate your pain at its worst: _____

Rate your pain at its best: _____

When is the pain worst? (please check)
Morning: ___ Midday: ___ Evening: ___

Does the pain interfere w/sleep?
Yes _____ No _____

Does the pain interfere w/daily routine? Yes _____ No _____

What decreases the pain? _____

_____

_____

PLEASE TURN OVER

PATIENT GENERAL HEALTH INFORMATION

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Describe your activity/exercise level (present):_____
(past): _____

What activities are difficult for you because of the pain or medical condition (i.e., dressing, money, checkbook management, walking). _____

_____

What are your goals/expectations for therapy? _____

_____

Have you ever been diagnosed with any of the following conditions? (Please check all diagnoses applicable)

__ Heart Disease	__ Low Vision	__ Heartburn
__ High Blood Pressure	__ Hearing Loss	__ Re□ux
__ Aneurysm	__ Diabetes	__ Infectious Disease
__ Emphysema/COPD	__ Kidney Disease	__ Incontinence
__ Asthma	__ Cancer	__ Allergies
__ Osteoarthritis	__ Thyroid Problems	__ Psychiatric Diagnosis
__ Rheumatoid Arthritis	__ Stroke	__ Depression
__ Other Arthritic Conditions	__ Seizure Disorder/Epilepsy	__ Anxiety
__ Lyme Disease	__ Vertigo/Balance Disorder	__ Chemical Dependency
__ Osteoporosis	__ Dif□culty Swallowing	__ History of Learning De□cit

Other:_____

Please indicate if you are currently pregnant: _____ Yes _____ No _____ N/A

Please list previous surgeries/procedures and approximate dates: _____

_____

_____

Please list any specialists you are seeing for this condition: _____

_____

During the past month have you often been bothered by feeling down, depressed or hopeless? ❒ Yes ❒ No

During the past month have you been bothered by little interest or pleasure in doing things? ❒ Yes ❒ No

Screening for Abuse and Neglect:

Are you in a relationship in which another person tries to control you? ❒ Yes ❒ No ❒ Unable to Respond

Has anyone physically harmed you in any way in the last 12 months? ❒ Yes ❒ No ❒ Unable to Respond

Do you feel **UNSAFE** at home due to abuse and neglect? ❒ Yes ❒ No ❒ Unable to Respond

Is there any other information you feel we should know?_____

_____

Please sign below to confirm that:
a) The above information is accurate to the best of your knowledge;
b) You agree to notify this facility with any changes to your status as a patient at Spaulding Rehabilitation Hospital Cape Cod - Outpatient Program.

Patient Signature	Date	Time	Therapist Signature	Date	Time
_____	_____	_____	_____	_____	_____