

Dora Roberts Rehabilitation Center

ADMISSION/INTAKE QUESTIONNAIRE

II. Patient Information

Date: _____

Patients: Please complete this form before meeting with your therapist.

B.1a First Name	B.1b Middle Initial	B.1c Last Name
B.2 Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
B.3 Birth Date _ _ / _ _ / _ _ _ _ <div style="display: flex; justify-content: space-around; font-size: small;"> MM DD YYYY </div>		

When do you see your doctor again (the doctor who referred you to therapy)? _____

When did your current symptoms start? _____ Surgery Date? _____

Are you currently receiving Home Health: _____ If Yes, which agency? _____

c.1 Primary Condition

**What are the main health conditions for which/reasons why you are receiving therapy?
Check all that apply.**

Check all that apply.	Problems of the muscles, ligaments, joints and/or bones	
	<input type="checkbox"/> a. General	<input type="checkbox"/> f. Knee, leg, and/or foot
	<input type="checkbox"/> b. Head and/or neck	<input type="checkbox"/> g. Shoulder
	<input type="checkbox"/> c. Back and/or pelvis	<input type="checkbox"/> h. Elbow
	<input type="checkbox"/> d. Ribs and/or collarbone	<input type="checkbox"/> i. Wrist, hand, and/or fingers
	<input type="checkbox"/> e. Hip	
	Other problems:	
	<input type="checkbox"/> j. General weakness	<input type="checkbox"/> p. Wound and/or skin problem
	<input type="checkbox"/> k. Problem with walking or balance	<input type="checkbox"/> q. Mental health condition
	<input type="checkbox"/> l. Problem of the heart and/or blood vessels	<input type="checkbox"/> r. Cancer
<input type="checkbox"/> m. Problem of the lungs and/or breathing	<input type="checkbox"/> s. Communication, voice, or speech disorder	
<input type="checkbox"/> n. Problem of the nervous system	<input type="checkbox"/> t. Swallowing disorder	
<input type="checkbox"/> o. Problems with eyes, inner ear, or ears	<input type="checkbox"/> u. Other condition(s)	

Please list all of your previous surgeries: _____

Please list all of your current medications: _____

II. Patient Information (cont.)

c.5 Other Medical Conditions

Has a doctor or other health professional ever told you that you have any of the following conditions? Please check all that apply.

- | | |
|--------------------------|--|
| <input type="checkbox"/> | a. Arthritis (rheumatoid and/or osteoarthritis) |
| <input type="checkbox"/> | b. Osteoporosis |
| <input type="checkbox"/> | c. Asthma |
| <input type="checkbox"/> | d. Chronic obstructive pulmonary disease (COPD), acquired respiratory distress syndrome (ARDS), emphysema, or asthma |
| <input type="checkbox"/> | e. Chest pain from your heart (such as angina) |
| <input type="checkbox"/> | f. Difficulty breathing or swelling in your legs because of your heart (such as congestive heart failure) |
| <input type="checkbox"/> | g. Heart attack (myocardial infarct) |
| <input type="checkbox"/> | h. Multiple sclerosis (MS), Parkinson's, or any other neurological condition |
| <input type="checkbox"/> | i. Stroke or transischemic attack (TIA) |
| <input type="checkbox"/> | j. Peripheral vascular condition |
| <input type="checkbox"/> | k. Diabetes |
| <input type="checkbox"/> | l. Ulcer, hernia, reflux, or any other upper gastrointestinal condition |
| <input type="checkbox"/> | m. Depression |
| <input type="checkbox"/> | n. Anxiety or panic disorders |
| <input type="checkbox"/> | o. Cataracts, glaucoma, macular degeneration, loss of visual field, or any other visual impairment |
| <input type="checkbox"/> | p. Spine/back problem, spinal stenosis, severe chronic back pain, or any other degenerative disc condition |
| <input type="checkbox"/> | q. High blood pressure |
| <input type="checkbox"/> | r. Headaches |
| <input type="checkbox"/> | s. Kidney, bladder, prostate, or urination problems |
| <input type="checkbox"/> | t. Allergies |
| <input type="checkbox"/> | u. Incontinence |
| <input type="checkbox"/> | v. Hepatitis |
| <input type="checkbox"/> | w. HIV/AIDS |
| <input type="checkbox"/> | x. Prostheses or implants |
| <input type="checkbox"/> | y. Sleep dysfunction |
| <input type="checkbox"/> | z. Cancer |
| <input type="checkbox"/> | aa. Other disorders: <i>Please write in</i> _____ |

It is our policy to provide Cardio-Pulmonary Resuscitation (CPR) when deemed medically necessary. If these are not your wishes, we must have a valid copy of your Living Will on file.

Please acknowledge: _____

Patient Signature

II. Patient Information (cont.)

E. Pain or Hurting

E.1 Pain Presence or Hurting

Have you had pain or hurting at any time during the last 7 days?

Yes	No	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E.2 Pain or Hurting Severity (Check one box.)

Please rate your worst pain during the last 7 days from 0 to 10, with 0 being no pain and 10 being the worst pain you can imagine.

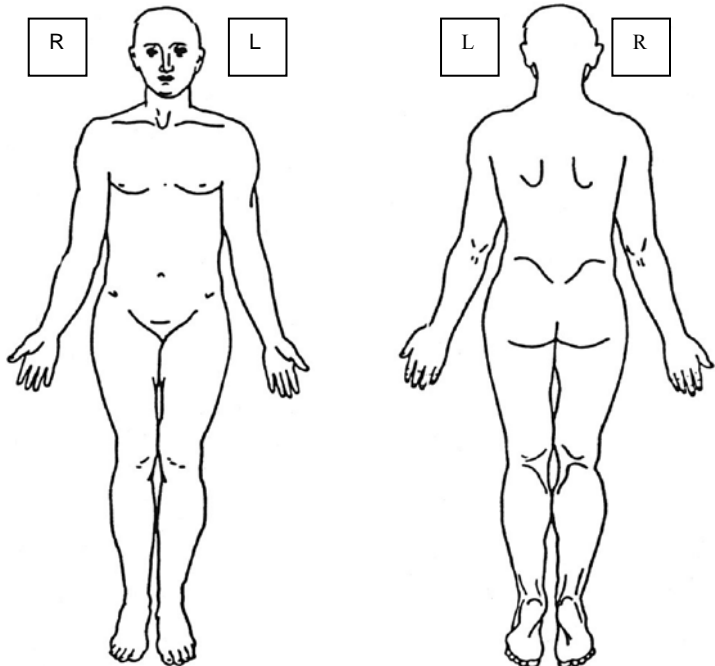
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10
No Pain					Moderate Pain					Worst Pain

E.3 Please describe your pain or hurting. (Check all that apply.)

Check all that apply.	<input type="checkbox"/> a. Constant	<input type="checkbox"/> e. Burning	<input type="checkbox"/> i. Ache/Throb	<input type="checkbox"/> m. Tightness
	<input type="checkbox"/> b. Intermittent	<input type="checkbox"/> f. Pinching	<input type="checkbox"/> j. Stabbing	<input type="checkbox"/> n. Stiffness
	<input type="checkbox"/> c. Sharp	<input type="checkbox"/> g. Numbness	<input type="checkbox"/> k. Pulling	<input type="checkbox"/> o. Other: Please write in
	<input type="checkbox"/> d. Dull	<input type="checkbox"/> h. Tingling	<input type="checkbox"/> l. Cramping	_____

E.4 Pain/Hurting Location

Please mark with an **X** the area(s) of your body where you have pain or hurting.



During the past 2 days, has pain made it hard for you to sleep?
 ___No ___Yes

During the past 2 days, have you limited your activities because of pain?
 ___No ___Yes

What days are you available for Therapy?

___Any Day ___Mondays ___Tuesdays ___Wednesdays ___Thursdays ___Fridays

What time of day is best for Therapy?

___Anytime ___Early Mornings ___Late Mornings ___Early Afternoons ___Late Afternoons

Is there anything else your therapist should know before therapy begins?