HOSPITAL FOR SPECIAL SURGERY

Rehabilitation Department
Outpatient Intake Form

Date _____
MR # _____

1. Name _____
Last First MI Jr/Sr
How do you wish to be addressed? _____

2. Preferred contact phone # _____

3. May we contact you via e-mail? ☐ Yes ☐ No
If so, please list E-mail address: _____

4. Date of birth / / **5.** ☐ Male ☐ Female

6. Language: English understood? ☐ Yes ☐ No
Interpreter needed? ☐ Yes ☐ No
What language do you speak most often? _____

7. Employment:
☐ Employed - Occupation _____
☐ On disability - Occupation _____
☐ Unemployed ☐ Retired
☐ Student ☐ Not yet working age

8. Who referred you to therapy? _____

9. Have you seen anyone else for this problem?
☐ Yes ☐ No If yes, who? _____

10. Have you had other therapy this year?
(i.e. OT, PT, speech, psychological) ☐ Yes ☐ No

11. What is your goal for therapy?
_____

12. What are your current activities & frequency?
_____

13. Have you ever had surgery? ☐ Yes ☐ No
If yes, please describe & include dates: (con't on back pg if needed)
_____
_____
_____

14. Medications - Do you take any non-prescription medications (check all that apply) ☐ None
☐ Advil/Motrin/Ibuprofen ☐ Aspirin/Bufferin
☐ Aleve/Naprosyn/Naproxen ☐ Decongestants
☐ Antacid ☐ Supplement/vitamin
☐ Antihistamines ☐ Tylenol
☐ Other _____
Do you take prescription medications? ☐ Yes ☐ No
If yes, please list: _____

15. General Health Please rate your health:
☐ Excellent ☐ Good ☐ Fair ☐ Poor
Have you had any recent major life changes (i.e. new baby, job change, death of loved one)? ☐ Yes ☐ No

16. Have you had any of the following in the past year?
☐ Bone scan ☐ EKG (electrocardiogram)
☐ CT scan ☐ EMG (electromyography)
☐ Ultrasound ☐ MRI
☐ X-rays ☐ Other _____

17. Are you allergic or sensitive to:
latex ☐ Yes ☐ No **adhesive tape** ☐ Yes ☐ No
Do you have any other significant allergies? ☐ Yes ☐ No
If yes, please list: _____

18. Medical History/THERAPY PRECAUTIONS
Please check if you've ever had, or *currently* have:
☐ **Asthma**
☐ **Blood Disorder**
☐ **Cancer**
☐ **Depression**
☐ **Head Injury**
☐ **Heart Problems**
☐ **Other** _____
☐ **High Blood Pressure**
☐ **High Blood Sugar/Diabetes**
☐ **Low Blood Sugar** (hypoglycemia)
☐ **Osteoporosis**
☐ **Seizures/Epilepsy**

Have you had any other physical problems in the past year we should be aware of? (i.e. shortness of breath, insomnia, dizziness): _____

19. Current limitations (Check all that apply)
Difficulty with ☐ movement ☐ transfers
Difficulty with walking: ☐ on levels ☐ on stairs
☐ endurance/distance ☐ on uneven surfaces
☐ Difficulty with self-care (i.e. bathing, dressing, eating)
☐ Difficulty with home management (i.e. household chores, shopping, driving/transportation)
☐ Difficulty during recreation or play activities

Do you need to use any of the following?
☐ Hand held support ☐ Cane
☐ Crutches ☐ Walker with / without wheels (circle)
☐ Stroller ☐ Wheelchair manual / power (circle)
☐ No devices needed for mobility

20. Where do you live?
☐ House ☐ Assisted living / group home
☐ Apartment ☐ Homeless (with or without shelter)
☐ Other: _____

Please describe your home situation:
☐ No stairs ☐ Stairs, no rail(s)
☐ Stairs, with rail(s) ☐ Ramps
☐ Elevator ☐ Uneven terrain

FOR THERAPIST USE ONLY:

SAFETY ISSUES:
☐ **BALANCE/FALL RISK** ☐ **COGNITIVE** ☐ **HEARING**
☐ **MEMORY** ☐ **POSITIONAL ISSUE** ☐ **VISION**
OTHER: _____

☐ **Pre/Post Treatment Considerations Reviewed & Discussed with patient**

_____
Therapist Signature Printed Name