ADM

Registration Date _____ Registration Time _____ Temporary Acct No: _____

Patient (Legal) Name: _____ Phone: _____

Patient Address: _____

Cell Phone: _____ Email: _____

Patient Date of Birth: _____ Sex: _____ Marital Status: _____

Race: _____ Religion: _____

Attending Physician: _____ Hospital Service Code: _____

Preferred Pharmacy: _____ Phone: _____

Reason for Service: _____

Emergency Contact Name: _____ Phone: _____

Address: _____

Relation to Patient: _____

Guarantor Name: _____ Phone: _____

Address: _____

Relation to Patient: _____

Patient Employer: _____ If Patient 18 Years of Age or Guarantor Employer Phone: _____

Employer Address: _____ Occupation: _____

Guarantor Employer: _____

PRIMARY INSURANCE

Name of Insurance Company: _____

Name of Insured: _____ Insured Policy No: _____

Relation to Patient: _____ Insured Date of Birth: _____

SECONDARY INSURANCE

Name of Insurance Company: _____

Name of Insured: _____ Insured Policy No: _____

Relation to Patient: _____ Insured Date of Birth: _____

Are you currently receiving home health care services? ☐ Yes ☐ No

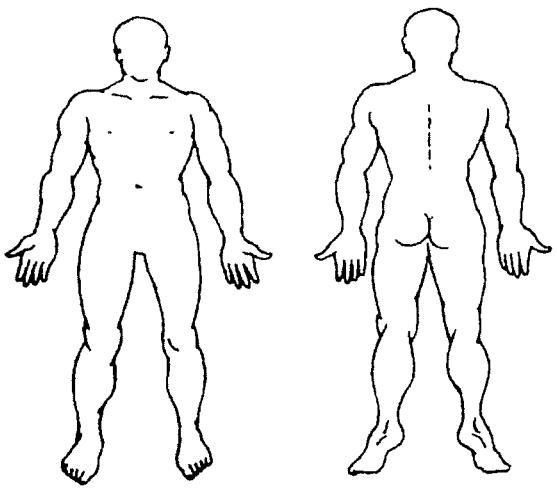
Patient Label

PA

PAIN SELF ASSESSMENT:

Where is your pain?

On the diagram to the right indicate pain location by shading the area involved. Refer to the key and place numbers that correspond to the pain's character over the appropriate shaded area. Also indicate area of numbness, ONLY if related to present injury or condition.



Key

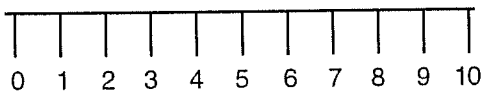
1. Dull ache
2. Stabbing
3. Pins and Needles
4. Burning
5. Numbness
6. Other _____

PAIN RELATED ISSUES:

Are you having pain now? ❑ Yes ❑ No

*(If you answered "yes", **use ONE of the scales below** to choose the number that best describes your present level of pain.)*

Numeric _____



0 1 2 3 4 5 6 7 8 9 10

No Pain — Moderate Pain — Severe Pain

Faces _____

0 2 4 6 8 10

Goal for pain relief? (number _____ **or** face _____ that represents your goal)

Acceptable level of pain? (number _____ **or** face _____ represents that level)

What methods of pain relief have you tried?

❑ Heat ❑ Non-prescription medications ❑ Herbal/homeopathic

❑ Cold ❑ Physical therapy ❑ Prescription Medications _____

❑ Relaxation/distraction ❑ Other _____

Were they successful in relieving your pain? ❑ Yes ❑ No

What activities make your pain worse? _____

What activities lessen your pain? _____

PERSON COMPLETING FORM:

Patient/Caregiver Signature:	Date:	Time:

Patient Label

REHAB

Please complete the following to the best of your ability. Your therapist will review this with you on your initial evaluation. After you have completed this form, please sign and date it on the bottom of page two (2).

Known Adverse and Allergic Reaction/Known Allergies

☐ **None on Initial Review**

Date	Allergy/Reaction	Date	Allergy/Reaction

Known Significant Medical Conditions Not Noted on Background Information Form

☐ **None on Initial Review**

Known Surgical and Invasive Procedures

☐ **None on Initial Review**

Date	Procedure

Known Current Medications: Prescription/Over the Counter/Herbals/Vitamins/Supplements

List routine medications, nutritionals, herbal supplements, patches, inhalers, ointments used.
If you have a list of medications on another document that we can attach, please **CHECK HERE** ☐
(see attached document with complete list of meds)

☐ **None on Initial Review**

MEDICATION (Include strength if known)	DIRECTIONS (if known)			Discontinued/Added (date and initial)
	DOSE	ROUTE	FREQUENCY	
Example: Aspirin 81 mg	*1 tab*	*by mouth*	*daily*	
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added
				☐ Discontinued ☐ Added

Patient Label

Known Current Medications: Prescription/Over the Counter/Herbals/Vitamins/Supplements

List routine medications, nutritionals, herbal supplements, patches, inhalers, ointments used.
If you have a list of medications on another document that we can attach, please **CHECK HERE** ☐
(see attached document with complete list of meds)

☐ **None on Initial Review**

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Patient Signature	Date/Time
Intake Therapist Signature	Date/Time
FOR CHANGES	
Therapist Signature	Date/Time
Therapist Signature	Date/Time
Therapist Signature	Date/Time
Therapist Signature	Date/Time

Patient Label

REHAB

To insure that you receive a complete and thorough evaluation along with referrals for any additional care required, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

Name: _____ Diagnosis: _____

Reason for coming to therapy: _____

Have you had this problem before? ☐ Yes ☐ No If yes, explain: _____

Have you had therapy for this condition before? ☐ Yes ☐ No

Your goals for therapy: _____

Are you *CURRENTLY* receiving home healthcare services? ☐ Yes ☐ No If yes, explain: _____

Occupation: _____

Leisure activities/hobbies: _____

Check all of the following providers whose care you are CURRENTLY receiving or have received in the PAST year.

☐ Physician	☐ Psychiatrist/Psychologist	☐ Chiropractor
☐ Physical therapist	☐ Podiatrist	☐ Dentist
☐ Occupational therapist	☐ Speech therapist	☐ Home health
☐ Ophthalmologist	☐ Other _____	

Have you ever been diagnosed with or currently have any of the following conditions? *(Check all that apply)*

☐ Cancer, what kind: _____	☐ Arthritic conditions	☐ Diabetes
☐ Heart problems or heart attack	☐ Depression	☐ Multiple sclerosis
☐ High blood pressure	☐ Headaches or TMJ dysfunction	☐ Hepatitis
☐ Circulation problems	☐ Tuberculosis	☐ Epilepsy or seizures
☐ Asthma	☐ Stroke or TIA's	☐ Rheumatoid arthritis
☐ Emphysema/bronchitis	☐ Kidney disease	☐ Anemia
☐ Chemical dependency (drug, alcohol)	☐ Metal implants or pacemaker	☐ Defibrillator
☐ Other _____	☐ Thyroid problems	☐ Osteoporosis

FOR WOMEN: Are you currently pregnant or think you MIGHT be pregnant? ☐ Yes ☐ No

Have you recently noted:

Weight loss or gain?	☐ Yes ☐ No		Fever, chills, or sweating?	☐ Yes ☐ No
Nausea or vomiting?	☐ Yes ☐ No		Numbness or tingling?	☐ Yes ☐ No
Do you have difficulty hearing?	☐ Yes ☐ No	☐ Right ☐ Left	Weakness?	☐ Yes ☐ No
Hearing aid?	☐ Yes ☐ No	☐ Right ☐ Left	Fatigue?	☐ Yes ☐ No

Do you require communication devices? ☐ Yes ☐ No If yes, what type _____

General Health Status

At the present time, would you say your health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is your best learning style? *(May choose more than one)*: ☐ Written ☐ Visual ☐ Verbal ☐ Return Demonstrate ☐ Other _____

Patient Label

Fall Assessment Needs

Have you fallen in the past six (6) months?	☐ Yes ☐ No
Do you take ANY of the following prescription medications: narcotics, high blood pressure medication, diuretics (water pills), heart medication?	☐ Yes ☐ No
Do you feel dizzy when you get up from a chair or bed?	☐ Yes ☐ No
Do you have uncorrected vision problems with reading or driving?	☐ Yes ☐ No
Are you over 65 years of age?	☐ Yes ☐ No

*If you answered yes to 2 or more questions, you could be at risk for a fall.
(Therapist-further assessment may be indicated)

Functional Needs

Have you had a significant DECREASE in your ability to perform any of the following items in the last 3 months?

Dressing yourself (including shoes, socks, zippers, buttons)?	☐ Yes ☐ No
Feeding yourself (including eating meat, handling utensils)?	☐ Yes ☐ No
Increased choking or problems with swallowing?	☐ Yes ☐ No
Slurred speech?	☐ Yes ☐ No
Other speech problems?	☐ Yes ☐ No
Problems with remembering the names of objects?	☐ Yes ☐ No
Grooming (including shaving, combing your hair, reaching the top and back of your head)?	☐ Yes ☐ No
Walking (including increasing dependence on a walker or cane)?	☐ Yes ☐ No
Stair climbing or walking up and down curbs or inclines?	☐ Yes ☐ No

Social Service Needs - Please indicate whether any of the following are true:

Do you live alone? If no, with whom? _____	☐ Yes ☐ No
Do you need a caregiver at home?	☐ Yes ☐ No
Do you have access to transportation?	☐ Yes ☐ No
Are your needs for food/nutrition, services and hygiene being met to avoid harm?	☐ Yes ☐ No
Have you experienced abuse including injury, intimidation, or punishment that resulted in physical harm, pain or anguish?	☐ Yes ☐ No
Is English your primary language? If no, please list primary: _____	☐ Yes ☐ No
Can you read/understand the English language?	☐ Yes ☐ No
Do you feel hopeless or helpless?	☐ Yes ☐ No
Has a family member or someone close to you committed suicide or have you been witness to a suicide?	☐ Yes ☐ No
Have you had thoughts of suicide?	☐ Yes ☐ No
Are you having any now?	☐ Yes ☐ No
Have you previously attempted suicide?	☐ Yes ☐ No
Do you have a plan to hurt yourself or someone else?	☐ Yes ☐ No

Where do you live? ☐ House ☐ Apartment ☐ Mobile Home ☐ Assisted Living ☐ Nursing Home ☐ Other _____

_____ _____ _____
Patient Signature Date Time

Referrals Made to the Following:

_____ _____ _____
Services Date Time

☐ Fall Assessment indicated based on screening and will be documented on the initial evaluation.

_____ _____ _____
Therapist Signature Date Time

(This form has been reviewed with the patient.)

Patient Label