HEART OF THE ROCKIES REGIONAL MEDICAL CENTER

Outpatient Rehabilitation Intake

Patient Name: Or
Patient DOB: Patient
Patient Number: Label
Admit/Visit Date:

Therapist Name: _____ Date of Eval: _____

Please complete the following. Feel free to ask your therapist for assistance with any items.

Last Name _____ First Name _____

Date of Birth_____	☐ MALE ☐ FEMALE	Height _____ Weight _____	☐ RIGHT Handed ☐ LEFT Handed

Reason for this visit? _____

Approximate Date of Onset: _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Occupation: _____ ☐ Full time ☐ Part time ☐ Not employed ☐ Retired

Describe your regular physical activities:

_____

Type of imaging study done for this condition? ☐ None ☐ MRI ☐ X-RAY

OTHER: _____

Y	N	
☐	☐	Are you pregnant? If so, how many weeks? _____
☐	☐	Do you have a pacemaker/defibrillator?
☐	☐	Have you had a joint replacement? If so, which joints? _____
☐	☐	Are you allergic to lotions/latex /tape/ menthol/medications? If so, please list: _____
☐	☐	Do you have adequate physical support at home to meet the challenges of your condition?
☐	☐	Do you feel safe at home?

Please list major injuries, surgeries or hospital stays (with reason for stay) and approximate dates:

In the past 6 months, have you had:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Difficulty with bowel/bladder control	☐	☐	Fever/Chills	☐	☐	Headache	☐	☐	Leg Swelling
☐	☐	Numbness in the genital or anal area	☐	☐	Numbness	☐	☐	Weakness	☐	☐	Nausea
☐	☐	Pain that wakes you at night	☐	☐	Dizziness	☐	☐	Shortness of breath	☐	☐	Chest pain
☐	☐	Unexplained weight change	☐	☐	Numbness	☐	☐				

Other: _____

Have you fallen in the last 6 months? ☐ Yes ☐ No If yes, how many times? _____

Have you ever been diagnosed as having any of the following:

Y	N		Y	N		Y	N	
☐	☐	Cancer If yes, what kind? _____	☐	☐	Emphysema/Bronchitis	☐	☐	Rheumatologic Conditions
☐	☐	Stroke	☐	☐	High Blood Pressure	☐	☐	Neuropathy
☐	☐	Heart Problems	☐	☐	Anemia	☐	☐	Epilepsy/Seizures
☐	☐	Kidney Disease	☐	☐	Thyroid Problems	☐	☐	Multiple Sclerosis
☐	☐	Diabetes	☐	☐	Osteoporosis/Osteopenia	☐	☐	Parkinson's
☐	☐	HIV/AIDS	☐	☐	Smoking	☐	☐	Other Neurologic Diagnoses
☐	☐	Hepatitis	☐	☐	Arthritis			If yes, what kind?
☐	☐	Tuberculosis	☐	☐	High Cholesterol			
☐	☐	Asthma	☐	☐	Chemical Dependency/Alcoholism			
			☐	☐	Depression			

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Other Conditions:

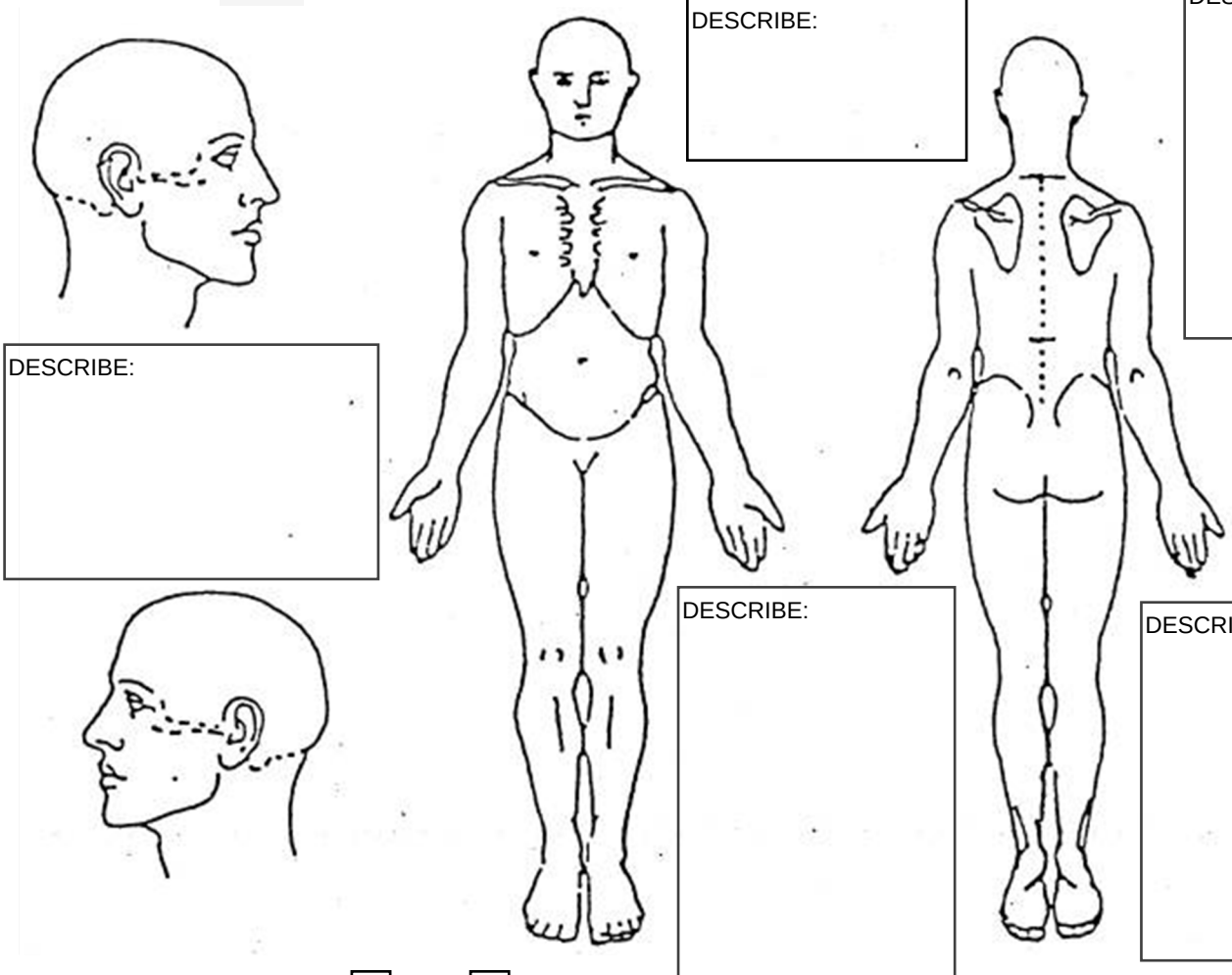
What prescription medications are you currently taking and what quantity? (include pills, injections, and skin patches)

Please check the number that best describes how your symptoms feel at your WORST:

No Discomfort **Worst Possible Discomfort**

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
No Hurt	Hurts	Hurts	Hurts	Hurts	Hurts	Hurts	Hurts	Hurts	Hurts	Hurts

Please mark and describe the areas where you feel symptoms (label pain, tingling, numbness, etc.) You should be able to mark with the Adobe tool



DESCRIBE:

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Form reviewed with patient? ☐ **YES** ☐ **NO**