



Affix Patient Label

Patient Name: _____

Date of Birth: _____

Please complete this form before you see the therapist. This information will help the therapy team to better understand your current condition and how we can work together to best meet your needs.

The following individuals have my consent to pick up or accept phone calls regarding my schedule: None

Please list: _____

What are the problems that bring you to therapy? _____

What date did these problems start? _____

What are your goals for therapy? _____

Have you ever had treatment for these problems in the past? No Yes I don't know

If yes, what kind? Surgery Physical Therapy Occupational Therapy Acupuncture Massage

Other _____

Where do you live? Home Apartment Group Home Assisted Living Other _____

Do you live alone? No Yes

Do you have to use stairs? No Yes How many? _____

Daily activity level:

Low (Example, I need help to do household chores, dress and bathe myself)

Medium (Example, I need some help, but can do about half on my own)

High (Example, I can do all household chores and self-care on my own, but have symptoms)

What daily activities are difficult now due to your current problems? _____

What kind of hobbies are you having a hard time doing? _____

Do you have access to gym equipment? No Yes What type? _____

Do you currently work? No Yes

If yes, what is your current work activity:

Regular Duty. I work _____ hours a day _____ days a week.

Limited or light duty. Date light duty began: _____

Off work currently. Date taken off work: _____

Can you return to work with restrictions? No Yes

If you are lifting at work, what is the average weight you lift? _____ Maximum weight _____

How many times per hour? _____

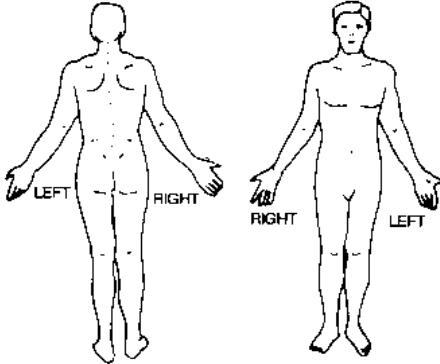
Height _____ Weight _____ What is your dominant hand? Right Left Both

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

Please mark the area(s) where you are experiencing the problems that brought you here.

Back

Front



Since these problems began, have you experienced any of the following?

- Change in appetite
- Change in vision
- Dizziness/Fainting
- Headache
- Numbness
- Shortness of breath
- Changes in bowel or bladder patterns
- Change in swallowing
- Falls/balance
- Memory problems
- Pain
- Tingling
- Changes in your mood
- Pregnancy
- Fever
- Night sweats
- Ringing in ears
- Unexplained weight loss/gain

Do you have any other conditions that may affect your healing and therapy? No Yes

Please describe: _____

Medical

Please check all that apply:

- I use tobacco: Cigarettes (_____ per day) Chew Pipe
- I drink alcohol. Number of drinks a day _____.
- I drink or eat caffeine. Number of servings a day _____.

Do you feel safe going home? No Yes

Do you feel adequately cared for? No Yes

Are you currently having thoughts of harming yourself? No Yes

Patient Signature: _____ **Date:** _____

Reviewed by: OT Signature _____ **Date:** _____

PT Signature _____ **Date:** _____

SLP Signature _____ **Date:** _____



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What tests have been done?

X-rays MRI CT Scan Bone Scan PET Other _____

Check here if any of these were completed at Bronson

Do you have any tests scheduled? No Yes What and when? _____

Please list all medicines you are taking (unless you brought a current list with you): _____

List any supplements, herbs, or changes to diet: _____

Please check all of the following conditions you have had:

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis – type _____ | <input type="checkbox"/> Birth defects |
| <input type="checkbox"/> Blood clots/circulation problems | <input type="checkbox"/> Cancer – type/area _____ | <input type="checkbox"/> Chronic anemia |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> GERD/Reflux |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart disease/chest pain/palpitations | <input type="checkbox"/> Hepatitis – A, B, C |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Kidney/bladder problems | <input type="checkbox"/> Liver/Gallbladder problems |
| <input type="checkbox"/> Lung disease/Asthma/breathing difficulties | <input type="checkbox"/> Metal implants | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Previous head injury | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Poor tolerance to cold |
| <input type="checkbox"/> Spinal stenosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Skin abnormalities |
| <input type="checkbox"/> Tuberculosis/Persistent cough | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid disease |

Please list any surgeries, fractures, dislocations or hospitalizations:

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

In the past month, have you used home health services? No Yes

In the past month, have you seen any other health providers? No Yes

If yes, who? _____