



REHABILITATION SERVICES – GENERAL INTAKE FORM PAIN/MEDICAL QUESTIONNAIRE (Page 1 of 2)

For Staff Use Only

Date: _____

Name: _____

Hospital #: _____

Physician: _____

TO BE COMPLETED BY PATIENT OR FAMILY MEMBER ON BEHALF OF PATIENT

- 1. Do you understand written English? Yes No
- 2. Do you understand spoken English? Yes No
- 3. Do you have visual problems that impair your ability to read? Yes No
- 4. Do you need an interpreter? Yes No
- 5. Do you have a hearing problem? Yes No
- 6. Are you or a family member being harmed or not taken care of? Yes No
- 7. Are there any customs/religious beliefs/rituals/wishes that might affect your care? _____

8. What is the reason for your visit today?

9. When did this problem begin?

10. Have you seen, or are you currently seeing anyone else for this problem(s): Yes No
If **Yes**, who? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Another Therapist | <input type="checkbox"/> OB/GYN |
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Orthopaedist |
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Osteopath |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Pain Specialist |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Pediatrician |
| <input type="checkbox"/> ENT | <input type="checkbox"/> Ophthalmologist |
| <input type="checkbox"/> Family MD | <input type="checkbox"/> Rheumatologist |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Neurologist |
| <input type="checkbox"/> Neuropsychologist | <input type="checkbox"/> Podiatrist |
| <input type="checkbox"/> Plastic Surgeon | <input type="checkbox"/> Dermatologist |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Other: _____ |

11. Have you ever had this problem(s) before? Yes No
If **Yes**, what did you do for it?

12. Did the problem(s) get better? Yes No

13. How are you taking care of the problem(s) now?

14. When is your next appointment with the physician who referred you to us? _____

15. Have you ever been told that you have: (Check all that apply)
- | | |
|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Low Blood Sugar/Hypoglycemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Broken Bones/Fractures | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Circulation/Vascular Problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Repeated Infections |
| <input type="checkbox"/> Developmental or Growth Problems | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Diabetes/High Blood Sugar | <input type="checkbox"/> Skin Diseases |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers/Stomach Problems |
| <input type="checkbox"/> Infectious Disease (such as Tuberculosis, Hepatitis) | <input type="checkbox"/> Mental Health Issues |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Reflux |
| | <input type="checkbox"/> Other: _____ |

16. List any surgeries that you have had:
Surgery: _____ Date: _____

17. Do you have a shunt? Yes No

18. Do you have a pacemaker? Yes No

19. Are you pregnant? Yes No Don't Know

20. Have you had any cancer? Yes No

21. Do you have a latex allergy? Yes No

22. Do you have skin sensitivities or allergies? (i.e., Tape) Yes No

If **Yes**, give details: _____





REHABILITATION SERVICES – GENERAL INTAKE FORM PAIN/MEDICAL QUESTIONNAIRE (Page 2 of 2)

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23. Within the past year, have you had any of the following? (Check all that apply.)

- | | |
|---|---|
| <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Joint Pain or Swelling |
| <input type="checkbox"/> Coordination Problem | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Difficulty Walking | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Dizziness or Blackouts | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Fever/Chills/Sweats | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Weakness in |

Arms/Legs

- | | |
|---|--|
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Open Wounds |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Loss of Sensation |
| <input type="checkbox"/> Weight Loss/Gain | <input type="checkbox"/> Other: _____ |

How much? _____

24. List all current prescriptions, over-the-counter medications and herbal supplements you are taking: (Use back if needed)

25. Do you have any difficulty taking medications as prescribed? Yes No
If Yes, give details: _____

26. List any drug or food allergies: (Sulfa, shellfish, iodine, IV dye, etc.)

27. Employment:

- Working Full-Time Working Part-Time
Occupation: _____

Are you off Work: Yes No

List any restrictions given to you by your Doctor:

- | | |
|---|--|
| <input type="checkbox"/> Homemaker | <input type="checkbox"/> Student |
| <input type="checkbox"/> Retired | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> On Disability? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
- As of what date? _____

28. With whom do you live? (Check all that apply)

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Alone | <input type="checkbox"/> Partner/Spouse |
| <input type="checkbox"/> Child(ren) | <input type="checkbox"/> Parent(s) |
| <input type="checkbox"/> Foster Care | <input type="checkbox"/> Grandparent(s) |
| <input type="checkbox"/> Other: _____ | |

29. Have you had any major life changes during the past year that would affect your care: Yes No
If Yes, please explain: _____

Testing:

30. Check all diagnostic testing already performed for this diagnosis, if any:

- | | |
|---|---|
| <input type="checkbox"/> Arterial Studies | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Audiogram | <input type="checkbox"/> Tissue Biopsy |
| <input type="checkbox"/> Bone Scan | <input type="checkbox"/> Venous Doppler |
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> Wound Cultures |
| <input type="checkbox"/> EMG | <input type="checkbox"/> X-Rays |
| <input type="checkbox"/> ENG | <input type="checkbox"/> Other: _____ |

Patient/Family Education:

31. If home instructions are prescribed, how do you learn them best? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Printed Material | <input type="checkbox"/> Verbal Instructions |
| <input type="checkbox"/> Demonstration | <input type="checkbox"/> Pictures |
| <input type="checkbox"/> Trial and Error | <input type="checkbox"/> Other: _____ |

Pain:

32. Do you have pain? Yes No

If Yes, where? _____



REGISTRATION
REHABILITATION SERVICES
PATIENT INFORMATION

Patient Name _____

Date of Birth _____ Social Security # _____ - _____ - _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Marital Status (please circle) Single Married Divorced Widowed

Patient Employer Name _____ Full or Part Time _____

Work Phone _____ Email Address _____

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Person Responsible for payment, if not patient:

Name _____ Date of Birth _____

.....

Patient Insurance _____ Policy # _____

.....

Was this an accident? (please circle) YES NO If yes, please complete the following:

Date of Accident _____ Time of Accident _____

Location of Accident _____

.....

Emergency Contact Name _____ Relation _____

Date of Birth _____ Home Phone _____ Cell Phone _____



REHABILITATION SERVICES – (SUPPLEMENTAL) OCCUPATIONAL THERAPY INTAKE FORM – ADULT (Page 3 of 3)

For Staff Use Only

Name: _____

Hospital #: _____

Physician: _____

Date: _____

**TO BE COMPLETED BY PATIENT OR
FAMILY MEMBER ON BEHALF OF PATIENT**

1. Do you have any adaptive equipment? (i.e., sock aid, bedside commode, grab bars, splints, etc.) Yes No

2. PLEASE CIRCLE YOUR CURRENT ABILITY TO PERFORM THE FOLLOWING TASKS USING THIS SCALE:

0 = No Difficulty

2 = Very Difficult/Moderate Assist

1 = Somewhat Difficult/Minimal Assist

3 = Unable to Perform/Maximum Assist

N/A = Does Not Apply

Dressing

Upper Extremity:	0	1	2	3	N/A	Comments: _____
Lower Extremity:	0	1	2	3	N/A	Comments: _____
Small Clothing Fasteners:	0	1	2	3	N/A	Comments: _____

Bathing

Upper Extremity:	0	1	2	3	N/A	Comments: _____
Lower Extremity:	0	1	2	3	N/A	Comments: _____

Feeding

Use (grip) Utensils:	0	1	2	3	N/A	Comments: _____
Cut Food:	0	1	2	3	N/A	Comments: _____
Deliver to Mouth:	0	1	2	3	N/A	Comments: _____

Fine Motor Skills

Pencil Grasp:	0	1	2	3	N/A	Comments: _____
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Leisure

Activity:	0	1	2	3	N/A	Comments: _____
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3. Describe any difficulties you may have with:

Lifting: _____

Carrying: _____

Pushing/Pulling: _____

Filing: _____

Writing/Typing: _____

4. Are you currently having pain? Yes No If Yes, please circle your pain level:

No Pain = 0 1 2 3 4 5 6 7 8 9 10 = Extreme Pain

Location of Pain: _____

Patient/Guardian Signature: _____ Date: _____

Reviewed By/Therapist Signature: _____ Date: _____





Indiana University Health

Thank you for choosing our Rehabilitation Services.

To help us better serve you:

GENERAL POLICY

- Return appointments are scheduled for 30 – 60 minutes. To allow optimal treatment time, please arrive **5 - 10 minutes** before your scheduled appointment to change clothes, use the bathroom, etc. If you arrive 15 minutes late for a scheduled appointment, you may have to:
 1. Wait to be seen by your therapist,
 2. Receive an abbreviated treatment,
 3. Be seen by another therapist, or
 4. Reschedule your appointment.
- Allow plenty of travel and parking time.
- If you are receiving Physical or Occupational therapy, please wear or bring appropriate clothing for the type of treatment you are receiving. Patient gowns are provided.

CANCELLATION

- **24 hour notification** is requested to cancel an appointment. Please call _____.
- If you miss an appointment, please call to confirm your next appointment time or to reschedule.
- Your consistent attendance and participation is imperative to your progress. Therefore, if the recommended plan of care is not followed and/or you are not making progress in your treatment plan, you will be discharged and your physician notified. If this occurs, a new referral for therapy will be necessary to set up a new therapy schedule.

ILLNESS

- Appointments should be cancelled if the patient has a fever of 100 degrees or above, vomited, or has been exposed to or diagnosed with an illness in the past 24 hours.
- If you have any questions about your care, please discuss with your therapist. We want to assist you with your rehabilitation. A supervisor may be contacted if you have further concerns.

BILLING

- If you have questions regarding the **billing** of our service, please call **Patient Financial Services General Information** at (317) 962-8661 or (800) 552-6871 Indiana only.
- If you need to obtain a copy of your medical records, contact **Health Information Management (Medical Records)** at 962-8911 or fax your request to 962-6285.
- To find out about insurance coverage for therapy services, please contact your insurance company.

I have read and agree to follow the above policy.

Patient Signature

Date