Indiana University Health

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 ______________________

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 _________

Indiana University Health

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

For Staff Use Only

Name:

Hospital #:

Physician:

Date: ____________________

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)*

☐ Another Therapist	☐ OB/GYN
☐ Acupuncturist	☐ Orthopaedist
☐ Cardiologist	☐ Osteopath
☐ Chiropractor	☐ Pain Specialist
☐ Dentist	☐ Pediatrician
☐ ENT	☐ Ophthalmologist
☐ Family MD	☐ Rheumatologist
☐ Massage Therapist	☐ Neurologist
☐ Neuropsychologist	☐ Podiatrist
☐ Plastic Surgeon	☐ Dermatologist
☐ Physiatrist	☐ 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)

☐ Allergies	☐ Low Blood Sugar/ Hypoglycemia
☐ Arthritis	☐ Liver Problems
☐ Blood Disorders	☐ Lung Problems
☐ Broken Bones/ Fractures	☐ Multiple Sclerosis
☐ Cerebral Palsy	☐ Muscular Dystrophy
☐ Circulation/Vascular Problems	☐ Osteoporosis
☐ Chemical Dependency	☐ Parkinson's Disease
☐ Depression	☐ Repeated Infections
☐ Developmental or Growth Problems	☐ Seizures/Epilepsy
☐ Diabetes/High Blood Sugar	☐ Skin Diseases
☐ Head Injury	☐ Stroke
☐ Heart Problems	☐ Thyroid Problems
☐ High Blood Pressure	☐ Ulcers/Stomach Problems
☐ Infectious Disease *(such as Tuberculosis, Hepatitis)*	☐ Mental Health Issues
☐ Kidney Problems	☐ Reflux
	☐ 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: ____________________

Indiana University Health

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

For Staff Use Only

Name:

Hospital #:

Physician:

23. **Within the past year,** have you had any of the following? *(Check all that apply.)*
    - ☐ Bowel Problems
    - ☐ Chest Pain
    - ☐ Coordination Problem
    - ☐ Cough
    - ☐ Difficulty Sleeping
    - ☐ Difficulty Swallowing
    - ☐ Difficulty Walking
    - ☐ Dizziness or Blackouts
    - ☐ Fever/Chills/Sweats
    - ☐ Headaches
    - ☐ Hoarseness
    - ☐ Joint Pain or Swelling
    - ☐ Loss of Appetite
    - ☐ Loss of Balance
    - ☐ Nausea/Vomiting
    - ☐ Pain at Night
    - ☐ Shortness of Breath
    - ☐ Urinary Problems
    - ☐ Vision Problems
    - ☐ Weakness in Arms/Legs
    - ☐ Hearing Problems
    - ☐ Heart Palpitations
    - ☐ Weight Loss/Gain
      How much? ________
    - ☐ Open Wounds
    - ☐ Loss of Sensation
    - ☐ Other: ________

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:
    ____
    - ☐ Homemaker
    - ☐ Student
    - ☐ Retired
    - ☐ Unemployed
    - ☐ On Disability? ☐ Yes ☐ No
      As of what date? ____

28. With whom do you live? *(Check all that apply)*
    - ☐ Alone
    - ☐ Partner/Spouse
    - ☐ Child(ren)
    - ☐ Parent(s)
    - ☐ Foster Care
    - ☐ Grandparent(s)
    - ☐ 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:
    - ☐ Arterial Studies
    - ☐ Audiogram
    - ☐ Bone Scan
    - ☐ CT Scan
    - ☐ EMG
    - ☐ ENG
    - ☐ MRI
    - ☐ Tissue Biopsy
    - ☐ Venous Doppler
    - ☐ Wound Cultures
    - ☐ X-Rays
    - ☐ Other: ________

Patient/Family Education:

31. If home instructions are prescribed, how do you learn them best? *(Check all that apply)*
    - ☐ Printed Material
    - ☐ Demonstration
    - ☐ Trial and Error
    - ☐ Verbal Instructions
    - ☐ Pictures
    - ☐ Other: ________

Pain:

32. Do you have pain? ☐ Yes ☐ No
    If ***Yes,*** where? ____
    ____
    ____
    ____
    ____
    ____
    ____
    ____
    ____

Indiana University Health

REHABILITATION SERVICES – (SUPPLEMENTAL)

PHYSICAL THERAPY/WOUND INTAKE FORM – ADULT (Page 3 of 3)

For Staff Use Only

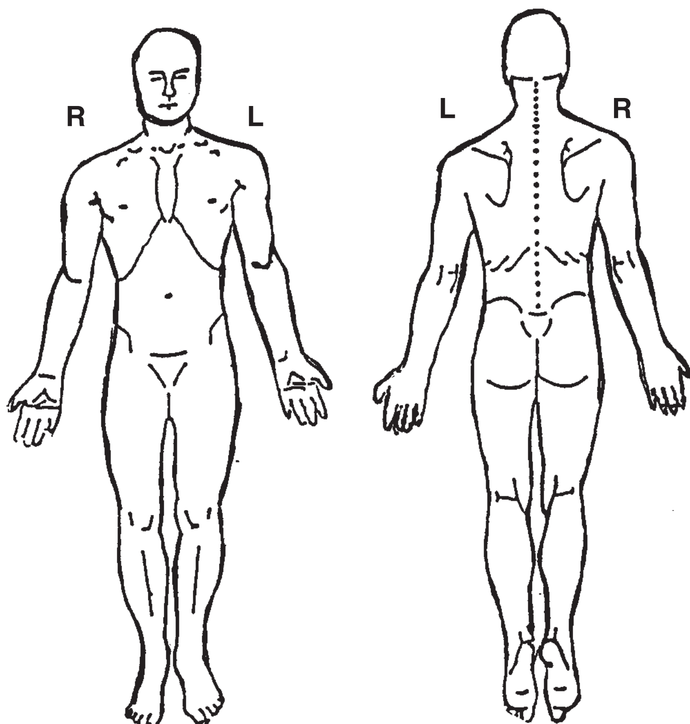
Name:

Hospital #:

Physician:

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

31. If you have pain, please indicate where it is located:



32. Circle your current pain level:

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

Patient/Guardian Signature: ______________________ Date: __________

Therapist Initials/Date: ______________________