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
    ☐ Acupuncturist
    ☐ Cardiologist
    ☐ Chiropractor
    ☐ Dentist
    ☐ ENT
    ☐ Family MD
    ☐ Massage Therapist
    ☐ Neuropsychologist
    ☐ Plastic Surgeon
    ☐ Physiatrist
    ☐ OB/GYN
    ☐ Orthopaedist
    ☐ Osteopath
    ☐ Pain Specialist
    ☐ Pediatrician
    ☐ Ophthalmologist
    ☐ Rheumatologist
    ☐ Neurologist
    ☐ Podiatrist
    ☐ Dermatologist
    ☐ 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
    ☐ Arthritis
    ☐ Blood Disorders
    ☐ Broken Bones/ Fractures
    ☐ Cerebral Palsy
    ☐ Circulation/Vascular Problems
    ☐ Chemical Dependency
    ☐ Depression
    ☐ Developmental or Growth Problems
    ☐ Diabetes/High Blood Sugar
    ☐ Head Injury
    ☐ Heart Problems
    ☐ High Blood Pressure
    ☐ Infectious Disease *(such as Tuberculosis, Hepatitis)*
    ☐ Kidney Problems
    ☐ Low Blood Sugar/ Hypoglycemia
    ☐ Liver Problems
    ☐ Lung Problems
    ☐ Multiple Sclerosis
    ☐ Muscular Dystrophy
    ☐ Osteoporosis
    ☐ Parkinson's Disease
    ☐ Repeated Infections
    ☐ Seizures/Epilepsy
    ☐ Skin Diseases
    ☐ Stroke
    ☐ Thyroid Problems
    ☐ Ulcers/Stomach Problems
    ☐ Mental Health Issues
    ☐ 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
      Occupation: ________________________
    - ☐ Working Part-Time

    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

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 – (SUPPLEMENTAL)

OCCUPATIONAL AND PHYSICAL THERAPY INTAKE FORM – PEDIATRICS (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. At what age did your child:
   - Hold his/her head up? ______________________
   - Roll over? ______________________
   - Sit alone? ______________________
   - Crawl? ______________________
   - Walk? ______________________
   - Run? ______________________

2. Was your child enrolled in First Steps or an early intervention therapy program? ☐ Yes ☐ No
   If ***Yes,*** check the therapies your child has received:
   - ☐ Physical Therapy
   - ☐ Occupational Therapy
   - ☐ Speech Therapy
   - ☐ Developmental Therapy

   If ***Yes,*** when was your child discharged and why? ______________________

3. Does your child currently attend other therapies? ☐ Yes ☐ No
   If ***Yes,*** check the therapies your child has received:
   - ☐ Hippotherapy (Horse Therapy)
   - ☐ Aquatic Therapy
   - ☐ School Therapy (OT, PT, Speech)
   - ☐ Occupational Therapy
   - ☐ Speech Therapy
   - ☐ Other

   If ***Yes,*** how often? ______________________

4. Does you child wear a brace/splints? ☐ Yes ☐ No
   If ***Yes,*** what kind of brace/splints? ______________________
   How old are the braces/splints? ______________________

5. Has your child ever received Botox injections? ☐ Yes ☐ No
   If ***Yes,*** at what facility/MD? ______________________
   Date of last injection: ______________________
   To which muscles? ______________________

6. Has your child ever had serial casting? ☐ Yes ☐ No
   If ***Yes,*** at what facility? ______________________
   When was the serial casting? ______________________
   What was serial casted? ______________________

7. Does your child use any equipment? ☐ Yes ☐ No
   If ***Yes,*** please check any that apply:
   - ☐ Wheelchair (manual / power)
   - ☐ Walker
   - ☐ Gait trainer
   - ☐ Stander
   - ☐ Crutches
   - ☐ Other

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