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
- ☐ 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
- ☐ Child(ren)
- ☐ Foster Care
- ☐ Partner/Spouse
- ☐ Parent(s)
- ☐ 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)
SPEECH 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 now or did you:
   - A. Sing in a choir? ☐ Yes ☐ No
     If ***Yes,*** what part? _____
     Describe your rehearsal schedule: _____
     _____
   - B. Hold a job requiring loud or continuous talking: ☐ Yes ☐ No
   - C. Participate in other activities (*i.e.,* sports, drama) which involved loud or continuous talking? ☐ Yes ☐ No
2. Have you made any attempts on your own to correct, improve or relieve your voice problems? ☐ Yes ☐ No
   If ***Yes,*** what have you tried? _____
   _____
   Did you get good results? ☐ Yes ☐ No
3. Have you had any injuries (falls, accidents, etc.) to your:
   - A. Face? ☐ Yes ☐ No
     If ***Yes,*** when? _____
     And what was the extent of the injury: _____
   - B. Head? ☐ Yes ☐ No
     If ***Yes,*** when? _____
     And what was the extent of the injury: _____
   - C. Neck? ☐ Yes ☐ No
     If ***Yes,*** when? _____
     And what was the extent of the injury: _____
   - D. Chest? ☐ Yes ☐ No
     If ***Yes,*** when? _____
     And what was the extent of the injury: _____
4. Do you or did you ever smoke? ☐ Yes ☐ No
   If ***Yes,*** how much? _____
5. Do any family members smoke? ☐ Yes ☐ No
   If ***Yes,*** how much? _____
6. Do you drink: ☐ Yes ☐ No
   If ***Yes,*** how much? _____
7. Can you breathe through your nose easily? ☐ Yes ☐ No
8. Does liquid go up through your nose easily? ☐ Yes ☐ No
9. Do you have trouble blowing up a balloon? ☐ Yes ☐ No
10. Do you have mucous in the throat or postnasal drip? ☐ Yes ☐ No
11. Are you bothered by a dry throat? ☐ Yes ☐ No
12. Do you cough or clear your throat a lot? ☐ Yes ☐ No
13. Do you have trouble swallowing? ☐ Yes ☐ No
14. Do you have any pain, discomfort or odd feelings in your throat? ☐ Yes ☐ No
15. Have you ever been told you have swallowing problems and/or are aspirating? ☐ Yes ☐ No
16. Have you ever been told to modify your diet due to swallowing problems? ☐ Yes ☐ No
17. Do you have a history of pneumonia or chronic respiratory problems? ☐ Yes ☐ No
18. Have you ever had a modified barium swallow study before? ☐ Yes ☐ No
    If ***Yes,*** where? _____
    If ***Yes,*** when? _____
    If ***Yes,*** what were the results? _____
    _____
    _____
    _____
    _____
19. Do you have difficulty thinking of words or understanding what others say to you? ☐ Yes ☐ No

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