The Rehabilitation Center

Charles A. Cannon, Jr. Memorial Hospital

Member of Appalachian Regional Healthcare System

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Patient History: to be completed by patient

Name:
_____

Sex: ☐ Male ☐ Female

Education:
Highest grade completed (circle one) 1 2 3 4 5 6 7 8 9 10 11 12
☐ Some college / technical school
☐ College graduate
☐ Graduate school / advanced degree

Social History:
Cultural / Religious: Any customs or religious beliefs or wishes that might affect care?
_____

With whom do you live:
☐ Alone
☐ Spouse only
☐ Spouse and other(s)
☐ Child (not spouse)
☐ Other relative(s) (not spouse or children)
☐ Group setting
☐ Personal care attendant
☐ Other: _____

Employment / Work (Job/School/Play)
☐ Working full time outside of home
☐ Working part-time outside of home
☐ Working full-time from home
☐ Working part-time from home
☐ Homemaker ☐ Student ☐ Retired ☐ Unemployed

Occupation: _____

Living Environment
Does your home have:
☐ Stairs, no railing
☐ Stairs, railing: 1 2
☐ Ramps
☐ Elevator
☐ Uneven Terrain
☐ Assistive Devices (eg, bathroom: _____
☐ Any obstacles: _____
_____

Where do you live:
☐ Private home
☐ Private apartment
☐ Rented room
☐ Board and care/assisted living / group home
☐ Homeless (with or without shelter)
☐ Long term care facility / nursing home
☐ Hospice

Outpatient Rehabilitation Evaluation

☐ PT ☐ OT ☐ SLP

Evaluation Date: _____

How did you hear about The Rehab Center?
☐ **Physician** ☐ **Website**
☐ **Friend or Family** ☐ **Advertisement**
☐ **Other:** _____

Social / Health Habits
Currently smoke / use tobacco? ☐ Yes ☐ No
Smoked in past? ☐ Yes ☐ No
Alcohol use? ☐ Yes ☐ No
Regular Exercise? ☐ Yes ☐ No

Current Condition / Chief Complaint(s)

Describe the problem (s) for which you seek therapy:
_____
_____

When did the problem(s) begin (mo/yr) _____/_____
What happened? _____
_____
_____
_____

Have you ever had the problem(s) before? ☐ Yes ☐ No
If yes, what did you do for the problem(s)? _____
_____
_____
Did the problem(s) get better? ☐ Yes ☐ No
How long did the problem(s) last? _____

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

What makes the problem(s) better? _____
_____
_____

What makes the problem(s) worse? _____
_____
_____

What activities and tasks were you able to do previously that because of this condition you are unable to do now?
1. _____
2. _____
3. _____

What are your goals for therapy?
1. _____
2. _____
3. _____

Effective Date: 01/08/2012
Revised Date: 04/07/2015
Form Number: 10691

T-ZZ025

CHARLES A. CANNON, JR. MEMORIAL HOSPITAL

Member of Appalachian Regional Healthcare System

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Outpatient Rehabilitation Evaluation

Family History

- ☐ Heart Disease
- ☐ Stroke
- ☐ Cancer
- ☐ Arthritis
- ☐ Hypertension
- ☐ Diabetes
- ☐ Psychological
- ☐ Osteoporosis
- ☐ Other:_____

Medical / Surgical History (Conditions)

Please check if you have ever had:

- ☐ Blood disorders
- ☐ Circulation / Vascular problems
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Lung Problems
- ☐ Stroke
- ☐ Diabetes/ high blood sugar
- ☐ Low blood sugar/ hypoglycemia
- ☐ Cancer
- ☐ Skin diseases
- ☐ Repeated infections
- ☐ Arthritis
- ☐ Broken bones/ fractures
- ☐ Osteoporosis
- ☐ Head Injury
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Seizures/epilepsy
- ☐ Developmental or growth problems
- ☐ Muscular dystrophy
- ☐ High cholesterol
- ☐ Thyroid problems
- ☐ Kidney problems
- ☐ Infectious disease
- ☐ Allergies
- ☐ Ulcers/stomach problems
- ☐ Depression
- ☐ Recent infection (cdiff, MRSA, VRE, ect.)
- ☐ Other:_____

Medical / Surgical History (Symptoms)

Within the past year, have you had any of the following symptoms? (check all that apply)

I. General Health System

- ☐ Fatigue
- ☐ Fever / chills/ sweats
- ☐ Nausea/ vomiting
- ☐ Change in sensation
- ☐ Weakness
- ☐ Balance/coordination issues
- ☐ Dizziness/Vertigo
- ☐ Malaise
- ☐ Pulsating Pain
- ☐ Persistent night pain

II. GI/Renal & Reproductive System

- ☐ Difficulty swallowing
- ☐ Heartburn/ Indigestion
- ☐ Food Intolerances
- ☐ Severe abdominal pain
- ☐ Changes in speech
- ☐ Loss of appetite
- ☐ Change in urinary frequency
- ☐ Pain with urination
- ☐ Incontinence
- ☐ Pain with intercourse
- ☐ Pregnant
- ☐ Menopause

III. Cardiovascular

- ☐ Dyspnea
- ☐ Palpitations
- ☐ Syncope/fainting
- ☐ Edema or swelling
- ☐ Unexplained cough
- ☐ Sever pain in calf
- ☐ Discolored, painful feet

IV. Pulmonary System

- ☐ Shortness of Breath
- ☐ Productive Cough
- ☐ Wheezing
- ☐ Clubbing of nails

V. Neurological System

- ☐ Frequent headaches
- ☐ Bowel dysfunction
- ☐ Vertigo
- ☐ Changes in hearing
- ☐ Unexplained falls
- ☐ Frequent ear infections

VI. Integumentary System(Skin)

- ☐ Discoloration
- ☐ Wounds
- ☐ Lacerations
- ☐ Bruises

Surgeries

Have you ever had surgery? ☐ Yes (please explain) ☐ No

_____
_____

Other Clinical Test Within the last year, have you had any of the following tests? (Check all the apply)

- ☐ Angiogram
- ☐ Arthroscopy
- ☐ Biopsy
- ☐ Blood tests
- ☐ Bone scan
- ☐ Bronchoscopy
- ☐ CT Scan
- ☐ Doppler ultrasound
- ☐ Echocardiogram
- ☐ EEG(electroencephalogram)
- ☐ EKG (electrocardiogram)
- ☐ EMG (electromyogram)
- ☐ ENG / calorics
- ☐ Mammogram
- ☐ MRI
- ☐ Myelogram
- ☐ NCV (nerve conduction velocity)
- ☐ Pap smear
- ☐ Pulmonary Function Test
- ☐ Spinal tap
- ☐ Stool tests
- ☐ Stress test (eg. treadmill, bicycle)
- ☐ Urine tests
- ☐ X-rays
- ☐ Other: _____

Are you seeing anyone else for the problem(s)?

- ☐ Accupuncturist
- ☐ Audiologist
- ☐ Cardiologist
- ☐ Chiropractor
- ☐ Dentist
- ☐ ENT
- ☐ Family practitioner
- ☐ Internist
- ☐ Massage therapist
- ☐ Home Health Services
- ☐ Neurologist
- ☐ OB/Gyn
- ☐ Occupational Therapist
- ☐ Orthopedist
- ☐ Osteopath
- ☐ Pediatrician
- ☐ Podiatrist
- ☐ Primary Care Physician
- ☐ Rheumatologist
- ☐ Other: _____

During the last 2 months have you been bothered by feeling down, depressed, or hopeless? ☐ Yes ☐ No

During that past month have you been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No

Is this something that you would like help with? ☐ Yes ☐ No ☐ Yes, but not today

Have you had any major life changes during the past year? (eg, new baby, job change, death of a family member) ☐ Yes ☐ No

_____

Patient Signature **Date**

For Therapist use: _____
_____
_____
_____

Reviewed by Therapist:

Signature: _____ Date/Time: _____

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