Huntington Health | An Affiliate of Cedars Sinai

Outpatient Rehab

Patient Name: _____ **Date:** _____

Home Street Address	**City/State/Zip Code**	**Home Phone**
Date of Birth	**Email Address**	**Cell Phone**
Emergency Contact	**Relationship**	**Contact Number**
Referring Physician	**Referring Physician Phone**	**Primary Care Physician**
Employer Name/Street Address	**City/State/Zip Code**	**Work Phone**

Primary Language: ☐ **English** ☐ **Spanish** **Other:** _____

If needed, is someone able to come with you to help translate? ☐ **Yes** ☐ **No**

Currently receiving any home care (Is a nurse or therapist coming to your home)? ☐ **Yes** ☐ **No**

Have you recently had any therapy services elsewhere? ☐ **Yes** ☐ **No**

If so, when and what condition(s) were you treated for: _____

Are you currently off of work due to your injury? ☐ **Yes** ☐ **No**

Reason(s) why you are here for therapy: _____

How did your injury/symptoms occur: _____

Date of your injury/surgery: _____

Other treatment(s) you have received: _____

Any tests for this condition (xray/MRI/etc): _____

List examples of limitations on daily routines: _____

Personal goal(s) for coming to therapy: _____

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I. MEDICAL HISTORY (Check the appropriate line)

	No	Yes		No	Yes
1. Heart Attack	___	___	12. Rheumatoid Arthritis	___	___
2. Heart Problems	___	___	13. Degenerative Arthritis	___	___
3. High Blood Pressure	___	___	14. Gout	___	___
4. Stroke	___	___	15. Fibromyalgia	___	___
5. Anemia	___	___	16. Seizures	___	___
6. Asthma	___	___	17. Osteoporosis	___	___
7. Emphysema	___	___	18. Kidney disease	___	___
8. Tuberculosis	___	___	19. Cancer	___	___
9. Depression	___	___	20. GI Disorder	___	___
10. Diabetes	___	___	21. Bowel/bladder problems	___	___
11. Multiple Sclerosis	___	___	22. Pregnant (women only)	___	___

23. Other illnesses diagnosed by a physician: _____

_____

II. SURGICAL/PROCEDURE HISTORY (Have you had any type of surgery or procedure?)

Surgery/Procedure	Date	Surgery/Procedure	Date
_____		_____	
_____		_____	

III. CURRENT MEDICATIONS

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. ALLERGIES

_____	_____	_____

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V. QUESTIONS RELATED TO YOUR SAFETY

1.	Is anyone not allowing you to obtain healthcare?	☐ Yes	☐ No
2.	Is anyone using your money, food, or housing against your wishes?	☐ Yes	☐ No
3.	Is any relationship causing you fear, emotional, or physical harm?	☐ Yes	☐ No
4.	Do you have any thoughts about harming yourself or others?	☐ Yes	☐ No
5.	Have you had any recent falls (within the last 1-2 months)?	☐ Yes	☐ No

VI. OTHER - Is there any other information that you think we should know?

____

____

Thank you!

***FOR REHAB PERSONNEL ONLY**

Any need for interpreter or use of AT&T interpreter line?	☐ Yes	☐ No	__________
Any barriers to learning identified (reading, writing, comprehension)?	☐ Yes	☐ No	__________
Has patient received patient safety brochure (“12 things…”)?	☐ Yes	☐ No	__________
Brochure reviewed with patient and patient understands?	☐ Yes	☐ No	__________
Reviewed insurance parameters with patient?	☐ Yes	☐ No	__________

Reviewed by: ____ **Date:** ____________________________