Huntington Health | An Affiliate of Cedars Sinai

Outpatient Rehabilitation

Patient Name: _____ **Date:** _____

Home Street Address	**City/State/Zip Code**	**Home Phone**
Date of Birth / Birthplace	**Email Address**	**Cell Phone**
Marital Status	**Religion**	**Preferred Pronouns**
Emergency Contact	**Relationship**	**Contact Number**
Referring Physician	**Referring Physician Phone**	**Primary Care Physician**
Employer Name/Occupation	**Street Address/City/State/Zip**	**Work Phone**

Primary Language:
□ English □ Spanish
Other: _____

Currently receiving any home care (is a nurse or therapist coming to your home)?
□ Yes □ No

Recently or currently have any therapy services elsewhere.
□ Yes □ No

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

_____
_____
_____

Are you currently off 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 (X-ray/MRI/etc.):

_____
_____

List examples of limitations on daily routines:

_____
_____
_____

Personal goal(s) for coming to therapy:

_____
_____
_____

Patient Name: _____ **Date:** _____

I. MEDICAL HISTORY (Check the appropriate line)

	Yes	No		Yes	No
1. Heart Attack			12. Rheumatoid Arthritis		
2. Heart Problems			13. Osteoarthritis		
3. High Blood Pressure			14. Gout		
4. Stroke			15. Fibromyalgia		
5. Parkinson's Disease			16. Seizures		
6. Anemia			17. Osteoporosis		
7. Asthma/Emphysema			18. Kidney Disease		
8. Tuberculosis			19. Cancer		
9. Depression/Anxiety			20. GI Disorder		
10. Diabetes			21. Bowel/Bladder Problems		
11. Multiple Sclerosis			22. Pregnant		

23. Other illnesses diagnosed by a physician:

_____

_____

II. SURGERIES / PROCEDURES / RECENT HOSPITALIZATIONS (please indicate dates if known)

_____ _____

_____ _____

_____ _____

_____ _____

III. CURRENT MEDICATIONS

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

IV. ALLERGIES

_____ _____ _____

_____ _____ _____

Patient Name: _____ **Date:** _____

V. QUESTIONS RELATED TO YOUR SAFETY

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

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

_____

_____

Thank you!

**********FOR REHAB PERSONNEL ONLY**********

	Yes	No	
Any need for interpreter or use of interpreter line?			
Any barriers to learning identified (reading, writing, comprehension)?			
Reviewed insurance parameters with patient?			

Reviewed by: _____ **Date:** _____