

PATIENT LABEL

Outpatient Clinical Assessment

Please complete the following questionnaire in order to expedite your evaluation process. Thank You!

Contact Information

Patient Name: _____

➤ Best Contact Number for above: Cell _____ Work _____ Home _____

Emergency Contact Name: _____

➤ Best Contact Number for above: Cell _____ Work _____ Home _____

Person Responsible for Scheduling (if other than patient): _____

➤ Best Contact Number for above: Cell _____ Work _____ Home _____

Parent/Guardian (if under the age of 18): _____

➤ Best Contact Number for above: Cell _____ Work _____ Home _____

Person to Contact regarding Therapy (if other than patient): _____

➤ Best Contact Number for above: Cell _____ Work _____ Home _____

Social / Other Demographics

Occupation: _____ Last Day Worked : _____

Current Living Situation: Alone Assisted Living Family/Relative Caregiver Other: _____

Is your current living situation different than prior to your illness? No Yes; If yes, how: _____

Do you have any difficulty getting around in your home? No Yes; Steps/How many: _____

Explain any difficulties: _____

What is the problem that brings you to therapy: _____ Date of Onset: _____

Is your condition due to: Auto Accident Fall Work Injury Other: _____

Is this a **workman's comp injury**? No Yes; If Yes, where were you when the injury occurred: _____

Have you had any of the following medical or rehabilitative services for *this* injury/episode?

Test / Service	YES	NO	Results / Outcomes
Physical or Occupational Therapy			
Speech Therapy or Swallow Study			
EMG/NCV			
Myelogram			
CT Scan			
MRI			
X-Ray			
Other:			
Home Health**			

** Please inform us if you are currently receiving Home Health services.

Check the box if you own or require the use of any of the following:

Assistive Devices: N /A Standard Walker Rolling Walker Hemi Walker Straight Cane

Large / Small Base Quad Cane Oxygen Splint / Brace Orthotics Prosthesis

Hearing Aid Eyeglasses / Contacts Dentures Pacemaker Vascular Stent

PEG Long Term Venous Access Other, Please Describe: _____

Bathroom Accessories: N /A Grab Bars Shower Chair Tub Bench Raised Toilet Seat

Bedside Commode Other, Please Describe: _____

Other Equipment: N /A Hospital Bed Wheelchair Cushion Other

Comments: _____



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Education / Activities/ Cultural - Religious Beliefs

Level of Education: Patient: 0-7th 8-12th College **Caregiver:** 0-7th 8-12th College

Primary Language: Patient: _____ **Caregiver:** _____

Barriers to Learning: _____

Motivation / Readiness to Learn: _____ **Preferred Method of Learning:** _____

Leisure Skills/Community Activities: _____

Are there any cultural or religious beliefs you feel may impact your care? If so, please explain:

Do you now or have you ever experienced any of the following?							
	Yes	No	Comments		Yes	No	Comments
Heart Attack/Surgery				Bowel / Bladder			
Heart Disease				Joint Replacement			
Pacemaker				Psychiatric History			
Circulation Problems				Epilepsy / Seizures			
Numbness/Tingling				Fatigue			
Arthritis				Weight Loss or Gain			
Osteoporosis				Swelling or Edema			
Stroke / TIA				Nausea / Vomiting			
Blood Clot / Emboli				Coughing / Sneezing			
Anemia				Ringing in Ears			
Infectious Disease				Depression			
Diabetes				Swallowing Problems			
Cancer				Severe Headaches			
Asthma				Problems Sleeping			
High Blood Pressure				Blurry/Double Vision			
Dizziness / Fainting				Skin Problems			
Chest Pain				Are you pregnant?			

Please list any previous surgeries or hospitalizations and associated dates:

Have you fallen in the last 3 months? No Yes

Are you on any special diet? No Yes; If so, what type: _____ Height: _____ Weight: _____

Have you had 3 episodes of diarrhea in one day within the last week? No Yes

Pain Assessment

Pain? No Yes **Pain Scale (0-10):** Now _____ Best _____ Worst _____

Frequency: Less than daily Daily Daily-Increases throughout day Constant Multiple daily episodes Night Pain
 Disturbed sleep Other; Please Explain: _____

Current Pain Relief Measures

Relaxation Techniques:

Medication:

Modality / Activity that decreases pain:

Modality / Activity that increases pain:

COMMENTS:



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Current Medications & Herbal Supplements

 Please check here if a typed list is included:

List All Allergies (food, etc.): _____

List Any Adverse Reactions to Medications: _____

DRUG	DOSAGE / FREQUENCY	DRUG	DOSAGE / FREQUENCY

MEDICATION UPDATES (TO BE COMPLETED BY THERAPIST)

DRUG	DATE /DOSAGE /FREQUENCY	DRUG	DATE /DOSAGE /FREQUENCY

 Is there anything we need to know that is not covered on this form? No Yes, please explain _____

What goals do you hope to accomplish by coming to therapy? _____

COMPLETE THIS SECTION ONLY IF PATIENT IS UNDER 21

 What childhood diseases have you had? Measles Chicken Pox Mumps Rubella

 Have you been exposed to any of these in the past three weeks? No Yes Explain: _____

PLEASE READ THE FOLLOWING AGREEMENT

In order to reach your optimum rehabilitation, it is essential that you follow your physician's prescribed treatment and the treatment plan established by your therapist. It is equally important that we are aware of any changes in your medical status and/or any changes in the medications you are taking. You are responsible for informing your therapist of any changes so we can maintain an accurate record in the event of an emergency. INITIALS _____

If you must cancel an appointment, please notify us as soon as possible so that we can reschedule your missed appointment within the week. We appreciate notification of cancellations 24 hours prior to scheduled appointments; this allows us to utilize your appointment time for other patients. A series of 2 no shows or cancellations may result in a discontinuation of services and notification to your physician of noncompliance. INITIALS _____

We are obligated to record all cancellations and no shows in your medical record. If you are covered by workman's compensation, we are obligated to report cancelled and "no show" appointments to your insurance carrier. INITIALS _____

_____ Patient / caregiver unable to complete form; information reviewed and completed by clinician. _____ INITIALS

Signature of Person Completing Form/Initials: _____ Date: _____



Outpatient Clinical Assessment

THIS PAGE TO BE COMPLETED BY LICENSED THERAPIST

Neuro/Emotional Status

- Alert and oriented to time, place, person
- Confused
- Lethargic
- Restless
- Hostile

- Calm and cooperative
- Anxious
- Agitated
- Depressed
- Uncooperative

- Speech clear
- Slurred
- Slow
- Aphasic
- Difficult to Understand

Other: _____

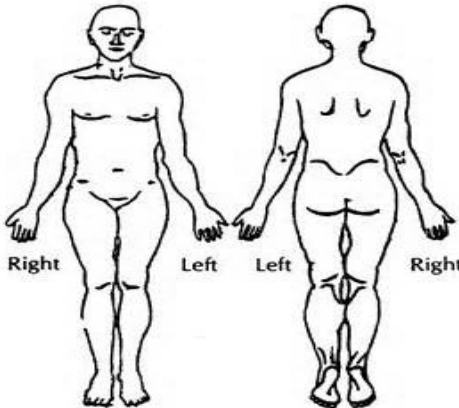
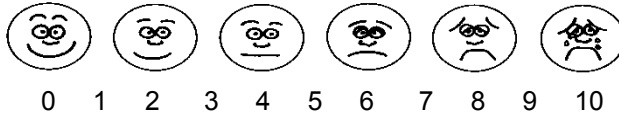
Skin Intact; Other: _____

Trigger Outpatient Case Manager / Social Worker for any YES answers below:

- | | | |
|--|------------------------------|-----------------------------|
| Evidence / Suspicion of abuse or neglect: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anticipated D/C needs (i.e. placement)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emotional status trigger from physical exam? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had changes in sleep patterns or sleep disturbances? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had any significant loss? (flood, move, family member, pet) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a history of anxiety or depression? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Date/Time trigger entered: ____ / ____ / ____ Time: _____ Comments: _____

Pain Assessment



Mark pain symptoms on the body chart using the following symbols:

- | | |
|-------------------------|-----------------------|
| Sharp Pain: //// | Numbness: 0000 |
| Dull Ache: **** | Radicular: ↓↓↓ |
| Burning: XXXX | |

Other Description: _____

Other Pertinent Information:

I have reviewed the Patient Information Record with patient/family prior to initiating assessment/evaluation:

Clinician Signature / Title / Initials: _____ Date/Time: _____

Clinician Signature / Title / Initials: _____ Date/Time: _____

Clinician Signature / Title / Initials: _____ Date/Time: _____

