

The information you provide is very important to your health and will help our staff determine the care you need as well as any further assessments. Please take time to fully and completely fill out this very important information. **NOTE: If you are currently receiving any type of home health care services, please see the receptionist before completing this form.**

**DATE:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**GENERAL INFORMATION:**

NAME:			DATE OF BIRTH:
HOME #:	CELL #:	WORK #:	OTHER CONTACT#:
EMAIL ADDRESS:			
REFERRING PHYSICIAN:		PRIMARY CARE PHYSICIAN:	
RETURN TO DOCTOR DATE:		ONSET DATE OF SYMPTOMS:	

**PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY**

**1. Reason for being referred to physical therapy / occupational therapy:**

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**2. Check all that apply and explain the following medical problems that you have had:**

- |                                       |   |  |  |  |
|---------------------------------------|---|--|--|--|
| <input type="checkbox"/> AIDS/HIV     | <input type="checkbox"/> Congenital Heart Defect  | <input type="checkbox"/> Fainting      | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Allergies    | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Fractures     | <input type="checkbox"/> Jaundice                | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Anemia       | <input type="checkbox"/> Convulsions              | <input type="checkbox"/> Glaucoma      | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Sinusitis           |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> COPD                     | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Stomach Ulcers      |
| <input type="checkbox"/> Back Trouble | <input type="checkbox"/> Dementia                 | <input type="checkbox"/> Heart Attack  | <input type="checkbox"/> Motor Vehicle Accident  | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Bronchitis   | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Heart Murmur  | <input type="checkbox"/> Osteoarthritis          | <input type="checkbox"/> Swelling Hands/Feet |
| <input type="checkbox"/> Cancer       | <input type="checkbox"/> Drug Abuse               | <input type="checkbox"/> Hepatitis     | <input type="checkbox"/> Psychiatric Treatment   | <input type="checkbox"/> Thyroid Disease     |
| <input type="checkbox"/> Chest Pain   | <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Herpes        | <input type="checkbox"/> Rheumatic Heart Disease | <input type="checkbox"/> Tuberculosis        |
|                                       |   |  | <input type="checkbox"/> Rheumatoid Arthritis    | <input type="checkbox"/> Rheumatic Fever     |

Explain as necessary:

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**3. List any operation or surgeries that you have had:**

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**4. List any medications you are currently taking:**

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**5. List any allergies and describe any drug reactions:** \_\_\_\_\_

Are you allergic to latex?  Yes  No

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**6. Please check any of the following you may have/wear:**

- Glasses  Contacts  Dentures  Pacemaker  Metal/Foreign Object Implant  Hearing Aides

## MOBILITY ASSESSMENT

What type of mobility device are you seeking to have? \_\_\_\_\_

- Cane  Walker  Manual Wheelchair  Power Scooter  Power Wheelchair

Do you plan to use this device inside your home?  Yes  No

Do you plan to use this device outside your home?  Yes  No

What condition do you have that requires the use of this mobility device? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

If this is a replacement device, why does it need to be replaced? When was it originally purchased? Who purchased the chair? \_\_\_\_\_

How do you currently get from one place to another in your home? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## CURRENT MEDICAL CONDITION

If you have pain, use the key below to indicate on the diagrams the appropriate symptom(s) and area(s) where you are having the most pain.

### PAIN INDICATOR

**KEY**

**X = Sharp Sensation**

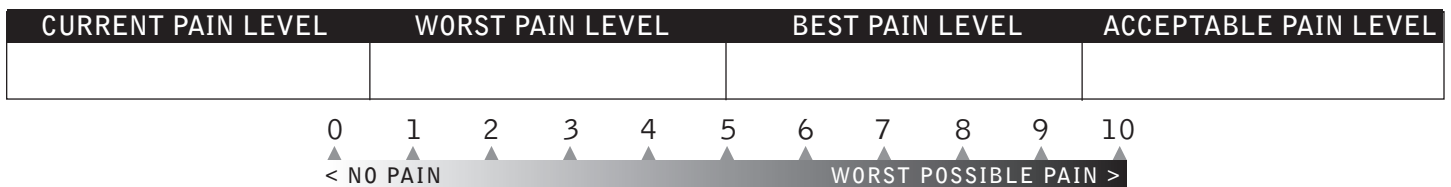
**O = Numbness or Tingling**

**# = Dull Aching**

**+ = Burning Sensation**

**> = Radiating Pain**

If you have pain, use the chart below to show your pain levels.



**HOME:**

What type of residence do you live in?  One story house  Multi-story house  First Floor Apartment  
 Second Floor or Higher Apartment

Do you own your home?  Yes  No

Do you have handicap modifications in your home (walk-in/roll-in shower, ramp, handicap toilet, etc.)?  Yes  No

Do you have steps into your home or in your home?  Yes  No How many? \_\_\_\_\_

**BATHING:**

Do you bathe in a shower, shower/tub combo, tub only? \_\_\_\_\_

Do you have a shower or tub seat?  Yes  No Do you use the seat?  Yes  No

Do you have a hand-held shower head?  Yes  No

Do you have assistance to bathe?  Yes  No If yes, what kind of assistance is provided? \_\_\_\_\_

Do you dry off while sitting or standing? \_\_\_\_\_

How long does it take for you to bathe? \_\_\_\_\_

How many days a week do you bathe? \_\_\_\_\_

**DRESSING:**

Do you dress while sitting, standing, lying or more than one position? Please clarify what is performed in which position? \_\_\_\_\_

Do you dress completely each day?  Yes  No

Do you have assistance to dress?  Yes  No If yes, what kind of assistance is provided? \_\_\_\_\_

How do you access your clothing? \_\_\_\_\_

**GROOMING:**

Do you groom while sitting or standing? \_\_\_\_\_

Where (location) do you groom? \_\_\_\_\_

Do you require assistance to groom?  Yes  No If yes, what kind of assistance is provided? \_\_\_\_\_

**TOILETING:**

Do you have a standard height or handicap toilet? \_\_\_\_\_

Do you have a toilet riser?  Yes  No

Do you use a bedside commode?  Yes  No

Do you have grab bars at your toilet?  Yes  No

Do you need assistance when toileting?  Yes  No If yes, what kind of assistance is provided? \_\_\_\_\_

Do you have issues of not making it to the toilet in time?  Yes  No If yes, how often does this occur? \_\_\_\_\_

**HOUSEHOLD CHORES:**

What household chores to you regularly complete? \_\_\_\_\_

What household chores have you stopped doing because you are physically unable to complete them? \_\_\_\_\_

Do you have assistance to complete household chores?  Yes  No If yes, what kind of assistance is provided? \_\_\_\_\_

**LAUNDRY:**

Do you do your own laundry?  Yes  No Do you complete all or part? What parts do you complete? \_\_\_\_\_

Is your washer/dryer in your home?  Yes  No If no, where is it located? \_\_\_\_\_

Do you need assistance to do your laundry?  Yes  No If yes, what kind of assistance is provided? \_\_\_\_\_

**MEALS:**

Are you able to prepare a light meal (sandwich, reheat a meal, etc.)?  Yes  No

Are you able to prepare a heavier meal?  Yes  No

Do you have assistance with meals?  Yes  No If yes, what kind of assistance is provided? \_\_\_\_\_

Do you ever skip meals due to inability to prepare the meal or fatigue?  Yes  No If yes, how often? \_\_\_\_\_

**SHOPPING:**

Do you shop for your own groceries?  Yes  No

How do you move around in the grocery store? \_\_\_\_\_

Do you have assistance with shopping?  Yes  No If yes, what kind of assistance is provided? \_\_\_\_\_

**DRIVING:**

Do you drive a vehicle?  Yes  No

If no, how do you get to your doctor's appointments and other activities? \_\_\_\_\_

**SLEEPING:**

Do you sleep in a regular bed, elevating bed, chair, etc.? \_\_\_\_\_

Do you use oxygen, CPAP or Bi-PAP when you sleep?  Yes  No If yes, what do you use? \_\_\_\_\_

**OTHER EQUIPMENT:**

Please mark which items you have in your home and you use:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Walker        | <input type="checkbox"/> Cane             | <input type="checkbox"/> Manual Wheelchair |
| <input type="checkbox"/> Power Scooter | <input type="checkbox"/> Power wheelchair | <input type="checkbox"/> Bedside commode   |
| <input type="checkbox"/> Toilet riser  | <input type="checkbox"/> Shower/tub seat  | <input type="checkbox"/> Oxygen            |
| <input type="checkbox"/> Lift chair    | <input type="checkbox"/> Ramp             | <input type="checkbox"/> Reacher           |

**To the best of my belief, this information is true and correct.**

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
THERAPIST SIGNATURE