Total Health
OFFERED BY STILLWATER MEDICAL CENTER

Mobility Intake Assessment
405.624.6592

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:

_____

_____

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

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

Explain as necessary:

_____

_____

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

_____

_____

4. List any medications you are currently taking:

_____

_____

5. List any allergies and describe any drug reactions: _____
Are you allergic to latex? ☐ Yes ☐ No _____

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? _____

_____

_____

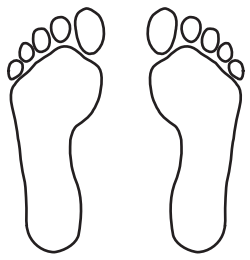
_____

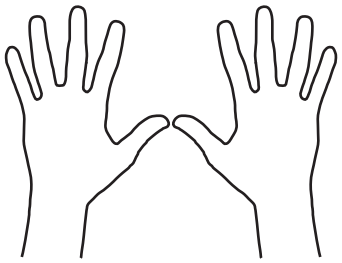
CURRENT MEDICAL CONDITION

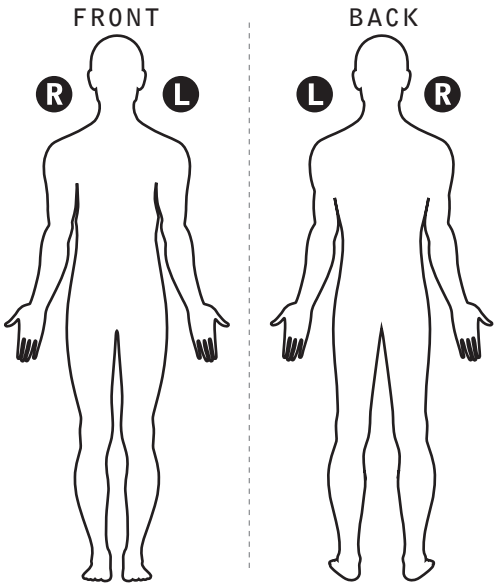
If you have pain, use the key below to indicate on the diagrams the appropriate symptom(s) and area(s) where you are having the most pain.

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.

CURRENT PAIN LEVEL	WORST PAIN LEVEL	BEST PAIN LEVEL	ACCEPTABLE PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

< NO PAIN WORST POSSIBLE PAIN >

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:

☐ Walker	☐ Cane	☐ Manual Wheelchair
☐ Power Scooter	☐ Power wheelchair	☐ Bedside commode
☐ Toilet riser	☐ Shower/tub seat	☐ Oxygen
☐ Lift chair	☐ Ramp	☐ Reacher

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

_____ PATIENT SIGNATURE

_____ THERAPIST SIGNATURE