Jefferson Health.
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Email Address:_____

OUTPATIENT THERAPY NETWORK Date: _____

Initial Patient Intake Form

Name:_____DOB: _____ MR#:_____

Diagnosis:_____Physician Name: _____

HISTORY OF CURRENT PROBLEM

- What is the problem?
- What is the onset date for the problem (mm/dd/yyyy)?
- What caused the problem?
- What makes the problem better/worse?
- Have you had any prior treatment for this problem/condition?
- Have you had this problem/condition before? YES NO
    - If YES, Did you get better?: YES NO SOMEWHAT

MEDICAL HISTORY

Do you have an out of hospital **DO NOT RESUSCITATE ORDER or POLST form**? Y N
If yes, please provide a copy. Copy provided? YES NO Date received _____.

Do you have any **INTERNAL STIMULATORS**? **(Please circle ALL that apply):**
PACEMAKER INTERNAL DEFIBRILLATOR DEEP BRAIN STIMULATOR

Have you ever been diagnosed with or treated for the following (hospitalization included)?
PLEASE CHECK ALL THAT APPLY

	YES	DATE
Alcohol Abuse		
Anemia		
Arthritis/ Rheumatism/ Gout		
Asthma		
Bleeding Tendency		
Bowel Disorder/ Colitis		
Cancer/ Tumors		
Depression		
Diabetes		
Drug Abuse		
Emphysema/Bronchitis		
Epilepsy/Seizures		

	YES	DATE
Gall Bladder Disease		
Head Injury/Loss of Consciousness		
Heart Problems or Increased Cholesterol		
High Blood Pressure		
Hepatitis		
Kidney, Bladder, Prostate Problems		
Nervous/Emotional Problems		
Osteoporosis		
Phlebitis		
Stomach Problems/ Ulcers		
Stroke		
Tuberculosis		

PATIENT NAME: _____ **MR#:** _____

Falls/Loss of Balance			Other:		

Have you had surgery for any reason including any of the above conditions? YES NO
If YES, please list and include dates:

Have you had any of the following within the past year? (Please circle <u>ALL</u> that apply)

Bowel/Bladder problems	Hearing problems
Chest pain	Heart palpations
Coordination problems	Hoarseness
Cough	Joint pain swelling
Difficulty sleeping	Loss of appetite
Difficulty swallowing	Nausea/ vomiting
Dizziness/ blackouts	Night pain
Falls/ Balance problem	Shortness of breath
Fever/ chills/ sweat	Urinary problems
Headaches	Vision problems

Other: _____

Please **<u>EXPLAIN</u> any circled items:

Have you had any weight gain/loss (> 10 pounds) in the past month? YES NO
If YES, how much? _____ Pounds Current height _____ Weight _____
Do you have a history of trauma you would like your therapist to be aware of?

_____

<u>Medications:</u>
Do you have any known adverse and allergic drug reactions: YES NO
If YES, List:_____

Please list ALL current medications and prescribing physician:

Medication	Prescribing Physician	Physician's phone number

Non prescription medications: _____
Vitamins/ minerals/supplements: _____
Are any of the above medications cytotoxic? YES NO

Pain/Current Condition limits which of the following?
(Please circle <u>ALL</u> that apply)

Movement
Walking (at home, level ground, uneven ground, ramps, curbs, stairs)
Standing Sitting
Self Care (Bathing, Dressing, Eating, and Toileting)
Home Management (Cleaning, Shopping, Chores)
Getting In and Out of Bed
Lifting Bending Driving
Work activities Leisure activities
Other: _____

PATIENT NAME: _____ **MR#:**_____

The following questions ask about your PAIN. Please refer to the following scale based on how your pain affects your sleep and daily activities:

FUNCTIONAL PAIN SCALE

Not Well Controlled	**Severe** Unable to engage in activities or sleep	10	Immobilizing	Needs ER, bedridden, unable to move, talk, or sleep
		9	Severe	Can't think about anything else, can barely talk. Can't sleep.
		8	Intense	Can't concentrate, conversation is difficult, activity and sleep not possible
	Moderate may interfere with activities, including sleeping	7	Blocking	Minimal sleep and activity possible; pain interferes significantly
		6	Distressing	Increasing activity but pain still prohibits regular activity, sleep interrupted
		5	Irritating	Pain tolerable, few activities limited by pain
		4	Distracting	Aware of pain but can continue with activities
Well Controlled	**Mild** generally does not interfere with activities or sleep	3	Uncomfortable	Pain is troubling but can be ignored
		2	Mild	Noticeable when not distracted
		1	Minimal	Hardly noticeable
		0	No pain	No pain

My CURRENT pain is rated as: _____ Location: _____
At WORST, my pain is 0 – 10: _____ At BEST, my pain is 0 – 10: _____

Cozean Pelvic Dysfunction Screening Protocol **CHECK ALL THAT APPLY:**

___ I sometimes have pelvic pain (in genitals, perineum, pubic or bladder area, or pain with urination) that exceeds a '3' on a 1-10 pain scale, with 10 being the worst pain imaginable

___I can remember falling onto my tailbone, lower back, or buttocks (even in childhood)

___I sometimes experience one or more of the following urinary symptoms

- Accidental loss of urine
- Feeling unable to completely empty my bladder
- Having to void within a few minutes of a previous void
- Pain or burning with urination
- Difficulty starting or frequent stopping/starting of urine stream

PATIENT NAME: _____ MR#:_____

___ I often or occasionally have to get up to urinate two or more times a night

___ I sometimes have a feeling of increased pelvic pressure or the sensation of my pelvic organs slipping down or falling out

___ I have a history of pain in my low back, hip, groin, or tailbone or have had sciatica

___ I sometimes experience one or more of the following bowel symptoms

- Loss of bowel control
- Feeling unable to completely empty my bowels
- Straining or pain with a bowel movement
- Difficulty initiating a bowel movement

___ I sometimes experience pain or discomfort with sexual activity or intercourse

___ Sexual activity increases one or more of my other symptoms

___Prolonged sitting increases my symptoms

SOCIAL HISTORY

Health Habits:

Do you smoke? YES NO # _____Packs per day Quit (Year) _____
How many days do you exercise in an average week? _____
How long is your average exercise session? _____Describe the exercise:_____

Employment:

(Please circle ALL that apply)

Full time Part time Unemployed Retired
Inside home Disability Student
Occupation: _____
If you are not currently working, do you plan to return to work? YES NO
Are you interested in changing jobs? YES NO

Home Set-Up:

Please Circle: 1-Story Home Multi-Story Home Apartment Other: _____
steps to enter: _____ with right rail/ left rail ramp elevator
steps to go upstairs: _____ with right rail/ left rail stair glide elevator
steps to go to basement: _____with right rail/ left rail stair glide elevator
Do you have a 1st floor set-up (Bed and Bathroom)? YES NO

Who do you live with? (Please circle ALL that apply)

Alone Parent Spouse Children Significant other
Parent (please specify):_____
Other (please specify):_____
Do you have any concerns about your personal safety? YES NO PREFER NOT TO ANSWER

Do you have any attendant care? YES NO Hours/day_____ Days/week_____
Do you have/use any medical equipment? (Please circle ALL that apply)

PATIENT NAME: _____ **MR#:**_____

Cane Quad Cane Crutches Walker (without wheels) Walker (with wheels)
Bracing Orthotics Prosthesis Electric Stimulation Devices
Manual Wheelchair Power Wheelchair
Shower Chair Commode
Other: _____

Cultural/ Religious:
Do you have any customs or religious beliefs that may affect care? YES NO

List 4 goals for therapy:
1.
2.
3.
4.

Do you have any other concerns or needs that we can be of assistance with?

REGISTRATION STAFF USE ONLY

Discussed Cancellation/No-Show Policy with patient?
Please circle: YES NO

Discussed Patient Health Profile with patient?
Please circle: YES NO

Patient's initials: _____ **Registration Staff initials:** _____

CLINICIAN STAFF USE ONLY

1. Patient understands and can apply basic information:
YES NO SOMEWHAT (Requires reinforcement)

2. Learning readiness of patient: Ready Not Ready No Interest Declines

3. Learning barriers: None Vision Hearing Language→Interpreter Needed
Unable to Read/ Comprehend What is Read Impaired Cognition
Other: _____

4. How does patient best learn? Pictures Reading Listening Demonstration
Other: _____

Therapist's signature(s) _____ **Date:** _____ **Time:** _____

_____ **Date:** _____ **Time:** _____