# OUTPATIENT HISTORY

This section staff use only

VERIFY PATIENT ID (2 required) ❑ NAME ❑ DOB ❑ OTHER

**DATE**___/___/____ Time

**AGE OF PATIENT** Age _____

**ACTUAL HEIGHT & WEIGHT** Height_____ Wt._____ ❑ N/A

**PREGNANT** ❑Yes ❑No

**BREASTFEEDING** ❑ Yes ❑ No

## PATIENT/FAMILY TO COMPLETE THE FOLLOWING:

**I. Health Problems**: **Check and / or circle if you have or had any of the following?**

| | Yes | | Yes | | Yes | | Yes |
|---|---|---|---|---|---|---|---|
| Diabetes | | High / Low Blood Pressure | | Difficulty Swallowing | | Depression / Anxiety | |
| Heart Problems/ Disease | | Pacemaker / AICD | | Seizures | | COPD/Pneumonia | |
| Asthma / Trouble Breathing | | Surgical Clips | | Difficulty Urinating | | Unsteady Walk / Falls | |
| Thyroid Problems | | Hepatitis / Liver Disease | | Arthritis | | Chest Pain | |
| Kidney Disease/ Dialysis | | Cancer_____(Type) | | Stroke | | Headaches/ Dizziness | |
| Surgery | | Chemotherapy | | TIA | | Migraine | |

**II. PAIN:** ❑No ❑Yes Circle number that describes the intensity of your pain: (1-3 mild, 4-7 mod, 8-10 severe) 1 2 3 4 5 6 7 8 9 10
Type / Quality: _____ Location: _____ Patient Stated Pain Goal (age appropriate scale 0-10)_____

**III. Previous Surgeries:** _____

**IV. Medications:** List all prescription and over-the-counter medications, herbal remedies, and/or supplements.

***PLEASE PRINT CLEARLY***

| Name of Medication | Dose | How Taken | How Often | Time Last Dose | Name of Medication | Dose | How Taken | How Often | Time Last Dose |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
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| | | | | | | | | | |

**V. Medication Allergies**
Have you had a true allergic reaction – such as 1. Red rash 2. Hives 3. Swelling 4. Shortness of breath 5. Wheezing– to any drugs? ❑No ❑Yes If Yes, state name of medication, and indicate type of reaction to each: _____

**VI. Medication Side Effects:**
Have you had a significant side effect – such as 1. Vomiting 2. Upset stomach 3. Diarrhea 4. Constipation 5. Headache - to any drugs? ❑No ❑Yes If Yes, state name of medication, and indicate type of reaction to each: _____

**VII. ALLERGIES:** Have you had an allergic reaction to food or other substance? ❑No ❑Yes If yes, list item and reaction:
_____

**VIII. Latex Allergy:**
When exposed to latex or rubber, (including rubber gloves used by you or your doctor, balloons, condoms) do you suffer runny nose, watery eyes, wheezing, or rash? ❑No ❑Yes, explain:_____
Do you have spina bifida or repeated catheterizations from congenital defects? ❑No ❑Yes, explain: _____
Do you have **breathing** reactions (wheezing, shortness of breath) to tropical or pitted fruits (e.g., bananas, kiwis, chestnuts, avocados, or cherries)? ❑No ❑Yes, explain _____

**IF YES HAS BEEN CHECKED OFF ONE OR MORE TIMES, USE LATEX PRECAUTIONS**

❑Latex precautions indicated and initiated ❑ Latex allergy education material provided to patient

**REVIEWED BY** _____ **PT/OT/ST** **❑ FAXED TO PHARMACY**

**OUTPATIENT HISTORY**
**REHAB**
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TORRANCE MEMORIAL MEDICAL CENTER

(01/18)

**PATIENT IDENTIFICATION**

TORRANCE MEMORIAL MEDICAL CENTER

# Rehabilitation Department - Patient Intake Form

**History:**

1) Date of injury and/or surgery: _____

2) Explain your condition, and describe how it began: _____

_____

_____

3) What treatment have you previously received for this condition, if any (injections, therapy, etc.)?_____

_____

4) Have your pain/symptoms been: ❑Improving ❑Not Changing ❑Worsening

5) What tests or labs were performed, & what were the results (X-ray, MRI, blood test, etc.)? _____

_____

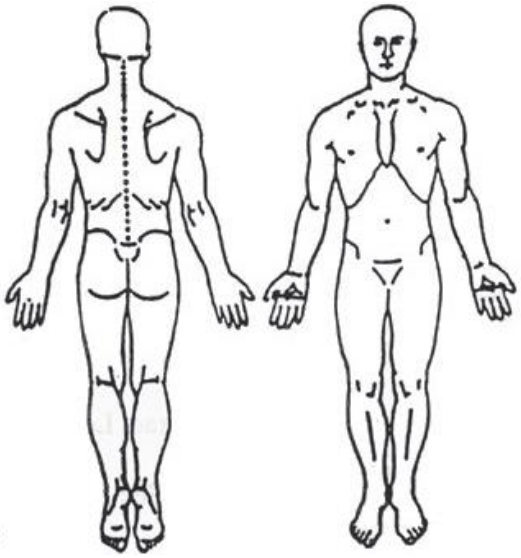
**Pain & Symptoms:**

1) Rate your symptoms from 0-10 in the past week (0 being no symptoms, and 10 being worst possible):
Currently: ___/10. At best (lowest): ___ /10. At worst (highest): ___/10.

2) Describe your symptoms (check below & **mark location on body chart)**:

| | | | |
|---|---|---|---|
| ❑Deep | ❑Aching | ❑Burning | ❑Shooting |
| ❑Superficial | ❑Tightness | ❑Throbbing | ❑Radiating |
| ❑Dull | ❑Pulling | ❑Pressure | ❑Numbness |
| ❑Sharp | ❑Cramping | ❑Heavy | ❑Tingling |

Other (please describe):_____



3) Does your pain/symptoms affect your sleep? ❑Yes ❑No
If yes, how many times a night does this wake you up? _____
Do you sleep on your: ❑Back ❑Side ❑Stomach

4) What percentage of the day do you have pain/symptoms?
❑0-25% ❑26-50% ❑51-75% ❑76-99% ❑100%

5) How long does it take for your pain/symptoms to **decrease** after performing an activity that causes it to worsen?
❑Immediately ❑Seconds ❑Minutes ❑Hours ❑Days

6) Are your symptoms **better** in the: ❑Morning ❑Afternoon ❑Evening
Are your symptoms **worse** in the: ❑Morning ❑Afternoon ❑Evening

7) What makes your pain/symptoms worse (i.e. movements, postures, positions)? _____

_____

8) What activities can you not perform or are difficult because of your pain/symptoms (i.e. recreations, daily tasks)? _____

_____

9) What do you do to decrease your pain/symptoms? _____

_____

**Occupation & Job Requirements:** _____

**Hobbies & Recreations:** _____

**What is your Goal for Therapy?** _____

**Medical History - List additional medical conditions, injuries or symptoms in other body parts (if not already stated):**

_____

_____

_____

**Check all that apply:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Cancer History | | Hearing Loss | | Unexplained Weakness | | Numbness/Tingling | |
| Weight Gain/Loss | | Chest Pain | | Shortness of Breath | | Change in Bowel/Bladder Habits | |
| Night Pain | | Recent Falls | | Unsteady or Loss of balance | | Recent Illness/Infection | |
| Nausea/Vomiting | | Fatigue/Malaise | | Fevers, Chills, or Night Sweats | | Difficulty Talking or Swallowing | |
| Vision Changes | | Memory Problems | | Unexplained Swelling | | Pain with Coughing or Sneezing | |
| Headaches | | Dizziness | | Joint clicking, locking, catching | | Leg Buckling or Giving Out | |

**FOR THERAPIST – ADDITIONAL NOTES:**

_____

_____

_____

_____

_____

**Patient Identification:**