Providence Rehabilitation Services New Patient Intake Form

Name: _____ Date of Birth: _____ Today's Date:_____

Primary Language:_____ Marital Status: ☐Single ☐Married ☐Widowed ☐Other

Allergies:_____

_____

Past Medical History: Have you EVER been diagnosed as having any of the following conditions?

☐Cancer. If YES describe what kind: _____	☐ Heart Problems
☐ High Blood Pressure	☐ Circulation Problems
☐ Asthma	☐ Emphysema/Bronchitis
☐ Chemical Dependency (i.e. alcoholism)	☐ Thyroid Problems
☐ Diabetes	☐ Multiple Sclerosis
☐ Arthritis	☐ Depression
☐ Hepatitis	☐ Tuberculosis
☐ Stroke	☐ Kidney Disease
☐ Epilepsy	☐ Osteoporosis
☐ Other Mental Health Diagnosis	☐ Sleep Apnea

Please list any **surgeries or major injuries** for which you have been treated for and date of surgery/injury:

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.

Please list any **PRESCRIPTION medications** you are currently taking (including pills, injections, and/or skin patches)

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.
11.	12.
13.	14.
15.	16.
17.	18.
19.	20.

Have you been feeling down, depressed, hopeless, or have little interest or pleasure in doing things? ☐Yes ☐No
For **WOMEN**: Are you currently pregnant or think you might be pregnant? ☐Yes ☐No

PERSONAL HABITS:
Tobacco Use: ☐Chew ☐Smoke Packs/day _____ # of years _____ Year Quit _____
Alcohol Use: ☐None ☐Social/Occasional ☐Weekly ☐Daily
Exercise: ☐None ☐Rarely ☐Occasional (<4s/wk for 30 min) ☐Regular (>4s/wk for 30 min)

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FALL RISK ASSESSMENT:

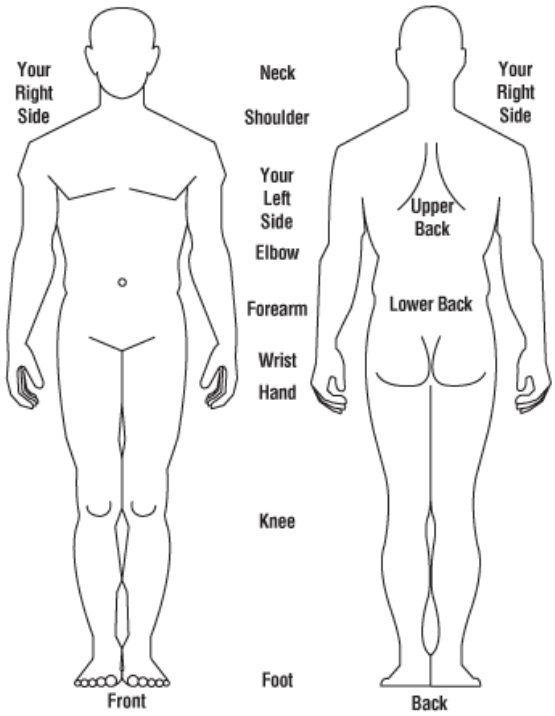
1. Have you fallen in the past year? ☐YES ☐NO
2. Do you feel unsteady when standing or walking? ☐YES ☐NO
3. Do you worry about falling? ☐YES ☐NO

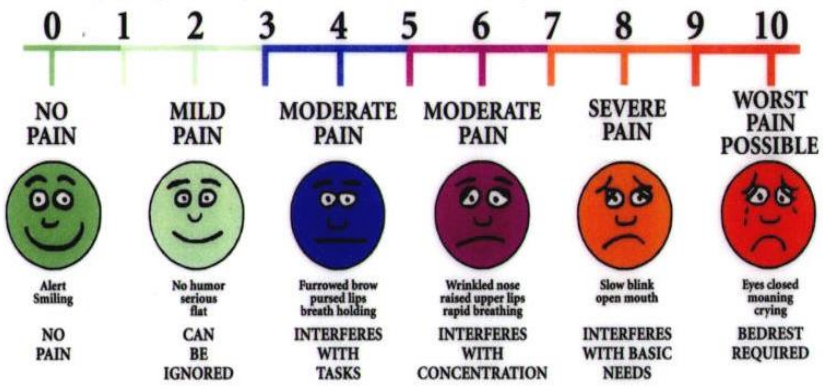
Because violence in the home is a serious health concern, we ask all patients about it:

1. Do you feel safe in your current relationship or home? ☐YES ☐NO
2. Is anyone in your life misusing your money or property? ☐YES ☐NO
3. Have you been hit, slapped, physically hurt or threatened by your partner? ☐YES ☐NO

How do you learn? ☐Listening ☐Reading ☐Observation ☐Performance of Task

Please mark on the diagrams where your symptom/pain is present and the level of pain:





Are there movements or activities that make your pain/symptoms consistently worse?

_____

_____