Adult OP Health Summary

St. Luke's Rehabilitation Institute
INLAND NORTHWEST HEALTH SERVICES

www.st-lukes.org

NAME: _____BIRTHDATE: ___/___/_____ Age**: _____** Sex ☐ M ☐ F

Name of Legal Guardian if patient is minor _____

Email Address:_____

Primary Phone: (____) _____ ☐ Mobile ☐ Home Alternative Phone: (____) _____

Emergency Contact: _____ (____) _____ _____
Name Phone # Relationship

Occupation: _____ Highest Level of education completed _____

LANGUAGE_____ ETHNICITY: (Mark box below)

☐Black/African American ☐Asian/Pacific American ☐White American
☐Native American/Alaskan Native ☐Latina/Latino/Hispanic American ☐Other_____

REASON FOR THERAPY _____

THERAPY GOALS:_____

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN:_____
HAVE YOU SOUGHT THERAPY ELSEWHERE WITHIN LAST 3 MONTHS?
☐NO ☐YES/LOCATION_____.

WHICH IS YOUR DOMINANT HAND? ☐Right ☐Left **HEIGHT_____ WEIGHT_____**

HAVE YOU EVER HAD A SPINAL CORD INJURY? ☐NO ☐YES

ALLERGIES: (Drug, Seasonal, Latex, or Food related**)** ☐NO ☐YES_____

MEDICAL HISTORY: (Mark a box if you have had any of these conditions and explain below)

☐ Anemia
☐ Anxiety/Depression
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Diabetes Mellitus
☐ Eye disease
☐ Hearing loss
☐ Heart Disease
☐ Hepatitis
☐ HIV / AIDS
☐ Hypertension (High Blood Pressure)
☐Injury Wrist/Hand
☐Injury Foot/Ankle
☐Injury Head
☐Injury Hip/Leg/Knee
☐Injury Shoulder
☐Injury Spinal/Neck
☐ Kidney Disease
☐ Mental illness
☐ Nerve/Muscle Disease
☐ Osteoporosis
☐Pacemaker/☐Defibrillator
☐ Pulmonary Disease/COPD
☐ Seizures
☐ Stroke
☐ Substance Abuse
☐ Thyroid Disease
☐ Tuberculosis
☐ Vision Loss
☐ Other (Please List) _____ Explain: _____

SURGICAL HISTORY: (Mark a box if you have had any surgical procedures and explain below)

☐Breast Surgery
☐ Eye Surgery ☐ Ear Surgery
☐ Fracture Surgery
☐Brain Surgery
☐ Heart Surgery
☐ Hysterectomy
☐ Prostate Surgery
☐ Small intestine Surgery
☐ Hernia Repair
☐ Joint Replacement
☐ Other (Please List) _____ Explain: _____

FAMILY HISTORY: (Please mark which family relative to the listed condition)

Arthritis_____ Cancer_____ Heart Problems_____
Anxiety/Depression_____ Diabetes_____ Other _____

ADDRESSOGRAPH

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SOCIAL HISTORY:

☐Smoking ☐ Vapor: ☐Currently use ☐Have used in the past ☐Use Every Day ☐Never used ☐Passive user
Alcohol use: ☐Yes ☐No Times per week_____ Drug Use: ☐Yes ☐No Times per week_____
Exercise**:** ☐ 1 time per day ☐ Few times per week ☐ Few times per month ☐ Never
Current Quality of Life/Health Status: ☐Excellent ☐Good ☐Fair ☐Poor

Do you have ☐transportation, ☐housing, or ☐financial concerns? ☐NO ☐YES_____

Are you concerned about your safety or violence at home? ☐NO ☐YES_____

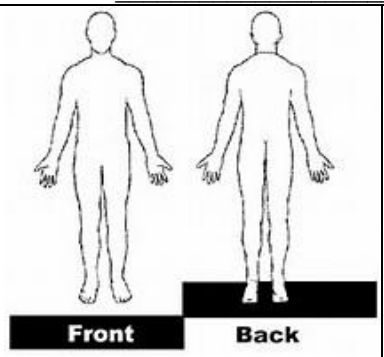
REVIEW OF SYSTEMS: (Please check all CURRENT symptoms)

TRAVEL RISK SCREENING: Have you or someone you are in contact with traveled out of the country within the year? ☐NO ☐YES/LOCATION_____.

General: ☐Chills ☐Fatigue ☐Fevers ☐Respiratory Symptoms ☐Joint/Muscle pain ☐Rash
Endocrine: ☐Pregnant or planning a pregnancy ☐Unintentional Weight Loss
ENT: ☐Hearing loss ☐Ear ringing ☐Ear pain ☐Congestion ☐Sore Throat
Eyes: ☐Blurred Vision ☐Eye pain ☐Double vision ☐Loss of vision ☐Light sensitivity
Cardio: ☐Chest pain ☐Palpitations ☐Leg/foot swelling

Urinary: ☐Blood in Urine ☐Urinary incontinence ☐Urinary retention
Neuro: ☐Dizziness ☐Tremors ☐Numbness ☐Seizures ☐Loss of balance
Psych: ☐Depression ☐Alcohol/Drug dependence ☐Anxiety
Gastrointestinal: ☐Heartburn ☐Nausea/Vomiting ☐Abdominal Pain ☐Blood in stool ☐Diarrhea
Hematologic / Lymphatic: ☐Bleeding ☐Blood clots ☐Blood transfusions ☐Bruising

Staff only:
☐Referred to PCP_____



MARK THE AREAS OF THE BODY WHERE YOU FEEL PAIN

Choose the number from pain scale that best describes your pain:
No pain+0 1 2 3 4 5 6 7 8 9 10+Maximum Pain

RIGHT NOW_____.
BEST day in past 30 days_____.
WORST day in past 30 days _____.

MEDICATION LIST: (**Please provide your complete list of Current Medications)**

Medication/Injection	Dosage	Prescribing Physician	Phone Number
_____	_____	_____	(____) _____
_____	_____	_____	(____) _____
_____	_____	_____	(____) _____
_____	_____	_____	(____) _____
_____	_____	_____	(____) _____

We have provided the following documents for your review:*(Copies are available upon your request)*
☐Patient Rights and Responsibilities ☐Consent to Treat ☐Attendance Policy

_____ _____ __/__/___
Signature of Patient or Legal Guardian Relationship to patient Date

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