RIVER GARDEN | Rehab
PERSONALIZED CARE WITH EXCEPTIONAL RESULTS

OUTPATIENT / CLIENT HISTORY MANAGEMENT FORM

DATE: _____

NAME: _____ **Date of Birth:** _____ **Male**† **Female**†
Last First MI Jr/Sr/Other MM/DD/YYYY

ADDRESS: _____
Street/PO Box City State Zip

TYPE OF INSURANCE: Insurer: _____ ☐ Medicare ☐ Self-pay ☐ Other ☐ Workers' Comp

1. **ARE YOU:**
Right-handed Left-handed

2. **RACE:**
American Indian
Alaska Native
Asian
Black or African American
Hispanic or Latino
Native Hawaiian or Other Pacific Islander
Caucasian

ETHNICITY:
Hispanic or Latino
Non-Hispanic or Latino
Interpreter Needed
_____

LANGUAGE:
English understood
Interpreter needed
Language spoken most often:
_____

3. **CULTURAL / RELIGIOUS:** Any customs or religious beliefs or wishes that might affect care:
_____
_____

4. **EDUCATION:**
Highest grade completed (Grade 1 thru 12): _____
Some college / technical school
College graduate
Graduate school / advanced degree

5. **WITH WHOM DO YOU LIVE:**
Alone
Spouse only
Spouse and Other(s)
Child (not spouse)
Other relative(s) (not spouse or children)
Group Setting
Personal care attendant
Other: _____

6. **HAVE YOU COMPLETED AN ADVANCE DIRECTIVE?** Yes No

7. **WHO REFERRED YOU TO PHYSICAL THERAPY / THERAPIST?**
_____

8. **EMPLOYMENT / PROFESSION (JOBS / SCHOOL / PLAY):**
Work full-time outside of home
Type of work _____
Working part-time outside of home
Working full-time from home
Working part-time from home
Homemaker
Student
Retired (type of work) _____
Unemployed

9. **WHERE DO YOU LIVE:**
Private home
Private apartment
Rented room
Board and care/assisted living/group home
Homeless (with or without shelter)
Long-term care facility (nursing home)
Hospice
Other: _____

10. **DOES YOUR HOME HAVE:**
Stairs but no railing
Stairs with railing
Ramps
Elevator
Uneven terrain
Assistive devices (e.g.: bathroom):
_____
_____
Any obstacles:
_____
_____

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11. **DO YOU USE:**

Cane	Glasses
Walker or rollator	Hearing aids
Manual wheelchair	Other: _____
Motorized wheelchair	_____

12. **GENERAL HEALTH STATUS:**

(a) Please rate your health:
Excellent Good Fair Poor

(b) Have you had any major life changes during the past year (e.g.: new baby, job change, death of a family member or loved one);
Yes No

If yes, please explain: _____
_____
_____

(c) Have you unintentionally lost ten pounds or more over the last year?
Yes No

(d) Maximal height in life: _____
Current height: _____
Current weight: _____

13. **SOCIAL / HEALTH HABITS:**

(a) **Smoking:**
-- Currently smoke tobacco: Yes No
Cigarettes (packs per day): _____
Cigars / Pipes (# times per day) _____
-- Smoked in the past: Yes No
Year quit: _____

(b) **Alcohol:**
-- On average, how many days per week do you drink beer, wine or other alcoholic beverages: _____
-- If one beer, one glass of wine or one cocktail equals one drink, how many drinks do you have during an average day: _____

(c) **Exercise:**
-- Do you exercise beyond normal daily activities / chores: Yes No
-- If yes, describe the exercise(s): _____
_____
On average, how many days per week: ____
How many minutes in average day: _____

14. **FAMILY HISTORY:** ***(Indicate if mother, father, brother/sister, aunt, uncle, grandmother/grandfather, and age of onset if known):***

Heart disease: _____
Hypertension: _____
Stroke: _____
Diabetes: _____
Cancer: _____
Psychological: _____
Arthritis: _____
Osteoporosis: _____
Other: _____

15. **MEDICATIONS:**

- Do you take any prescription medications:
Yes No
- If yes, please list (or attach list to this form):
_____
_____
_____
_____
_____
_____
_____
- Do you take any non-prescription medication?
(Check all that apply):
Advil / Aleve
Antacids
Ibuprofen / Naproxen
Antihistamines
Aspirin
Decongestants
Herbal supplements
Tylenol
Other: _____
_____
_____
_____
_____

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16. **CLINICAL TESTS:** ***(Within the past year, have you had any of the following tests? Check all that apply):***

- Angiogram
- Arthroscopy
- Biopsy
- Blood tests
- Bone mineral density
- Bone scan
- Bronchoscopy
- CT scan
- Doppler ultrasound
- Echocardiogram
- EEG (electroencephalogram)
- EKG (electrocardiogram)
- EMG (electromyogram)
- X-rays
- Mammogram
- MRI
- Myelogram
- NCV (nerve conduction velocity
- Pap smear
- Pulmonary function test
- Spinal tap
- Stool tests
- Stress test (e.g.: treadmill, bicycle)
- Urine tests
- Other

17. **MEDICAL / SURGICAL HISTORY:** ***Please check if you have ever had any of the following:***

- Arthritis
- Broken bones / fractures
- Osteoporosis
- Blood disorders
- Circulation / Vascular problems
- Heart problems
- High Blood Pressure
- Lung problems
- Stroke
- Diabetes / High Blood Sugar
- Low Blood Sugar / Hypoglycemia
- Head injury
- Depression
- Multiple Sclerosis
- Parkinson disease
- Seizures / Epilepsy
- Allergies
- Developmental or growth problems
- Thyroid problems
- Cancer
- Infectious disease (e.g.: TB, Hepatitis)

17. **MEDICAL / SURGICAL HISTORY (Cont.)**

Please check if you have ever had any of the following:

- Kidney problems
- Repeated infections
- Ulcers / stomach issues
- Skin diseases
- Other: _____
  _____
  _____

Within the past year, have you had any of the following symptoms (check all that apply):

- Chest pain
- Heart palpitations
- Cough
- Hoarseness
- Shortness of breath
- Dizziness or blackouts
- Coordination problems
- Weakness in arms or legs
- Loss of balance
- Difficult walking
- Joint pain or swelling
- Pain at night
- Difficulty sleeping
- Loss of appetite
- Nausea / Vomiting
- Difficulty swallowing
- Bowel problems
- Weight loss / gain
- Urinary problems
- Fever / chills / sweats
- Headaches
- Hearing problems
- Vision problems
- Other: _____
  _____

Have you ever had surgery: Yes No

If yes, please describe and indicate dates:

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

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17. **MEDICAL / SURGICAL HISTORY (Cont.)**

Please check if you have ever had:

Light headedness
Dizziness
Sensation of spinning or vertigo (while going from lying to sitting, sitting to standing or during head movements)
Visual problems
- When was your last eye exam: _____

Eye Surgery
Hearing difficulties
- When was your last hearing exam: _____

For men only:
Have you been diagnosed with prostate disease:
Yes No

For women only: *Have you been diagnosed with:*

Pelvic inflammatory disease:	Yes	No
Endometriosis:	Yes	No
Trouble with your period:	Yes	No
Complicated pregnancies or deliveries:	Yes	No
Pregnant or think you are:	Yes	No
Other gynecological or Obstetrical difficulties:	Yes	No

If yes, please describe:

_____
_____
_____

18. **CURRENT CONDITION(S) / CHIEF COMPLAINTS:**

- Describe the problem(s) for which you are seeking PT: _____
  _____
- When did the problem(s) begin: Date: _____
  What happened: _____
  _____
  _____
- Have you ever had the problem before:
  Yes No
  If yes, what did you do for the problem(s): _____
  _____
  _____
  _____

18. **CURRENT CONDITION(S) / CHIEF COMPLAINTS (Cont.):**

- Did the problem get better:
  Yes No
- How long did the problem last:
  _____
- How are you taking care of the problem now: _____
  _____
  _____
- What makes the problem better:
  _____
  _____
- What makes the problem worse:
  _____
  _____
- What are your goals for physical therapy:
  _____
  _____
  _____

Are you seeing anyone else for the problem(s): *(Check all that apply):*

Acupuncturist
Cardiologist
Chiropractor
Dentist
Family practitioner
Internist
Massage therapist
Neurologist
Obstetrician / Gynecologist
Occupational therapist
Orthopedist
Osteopathy
Pediatrician
Podiatrist
Primary care physician
Rheumatologist
Other: _____
_____
_____
_____

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19. **FUNCTIONAL STATUS / ACTIVITY LEVEL**
(Check all that apply)

Difficulty with locomotion / movement:
- Bed mobility
- Transfers (such as moving from bed to chair, from bed to commode)
- Gait (walking)
  - On level surface
  - On stairs
  - On ramps
  - On uneven terrain

Difficulty with self care (such as bathing, dressing, eating, toileting)

Difficulty with home management (such as household chores, shopping, driving / transportation, care of dependents)

Difficulty with community and work activities / integration
- Work / School
- Recreation or play activity

Have you fallen in the last year: Yes No

If yes, how many times: _____

Do you have a fear of falling: Yes No

How many times did you leave your home within the last week:
- Daily
- 1 x/week
- 3 x/week
- Other

Do you need assistance to leave your home:
Yes No

If yes, what type of assistance:
- Assistive device
- Personal assistance

Do you receive any care in your home?
- Nursing Care
- Drawing Blood (INR's / checking labs)
- Home Health Aide
- PT / OT Services

20. **OTHER INFORMATION YOU WOULD LIKE TO SHARE:**