

Patient's History of Current Injury/Illness

Washington Outpatient Rehabilitation Center
39141 Civic Center Dr. Ste. 120 Fremont CA
(510) 794-9672 Fax: (510) 792-8138

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Sex: _____ Marital Status _____ # Children _____ Ages _____

Occupation: _____ R-handed _____ L-handed _____ Ht. _____ Wt. _____

Have you ever been a patient here before? Yes ___ No ___; If yes, for the ___ same or ___ different problem?

Please indicate for which body region you are seeking treatment:

___ Neck ___ Mid Back ___ Low Back ___ Shoulder ___ Elbow ___ Hand/wrist ___ Hip ___ Knee ___ Ankle/foot ___ Other _____

When did your symptoms start? Date _____ Can you identify a cause for your symptoms? Yes ___ No ___

If yes, specify: _____

Have you ever had similar symptoms in the past? Yes ___ No ___ If yes, when? _____

MEDICARE

1. Have you received any services at home from a home health agency related to this condition?

Yes No If yes, when? _____ Have you been discharged? Yes No

2. Were you admitted in a skilled nursing facility for the related condition? Yes No

If yes, when? _____

Is the injury due to Car Accident? Yes No

Have you recently had the following tests? Yes ___ No ___ If yes, check all that apply:

___ X-rays ___ Bone Scan ___ Myelogram ___ EKG
___ CT Scan ___ EMG ___ Stress Test ___ Echocardiogram
___ MRI ___ Blood Tests ___ Pulmonary Function Test ___ Other (Please list) _____

Pain rating: Indicate your average level of pain by circling the appropriate number on the scale below:

0 1 2 3 4 5 6 7 8 9 10

Pain free

Unconscious Pain

Describe the character of your pain? (What does it feel like...sharp, dull, achy, etc.?)

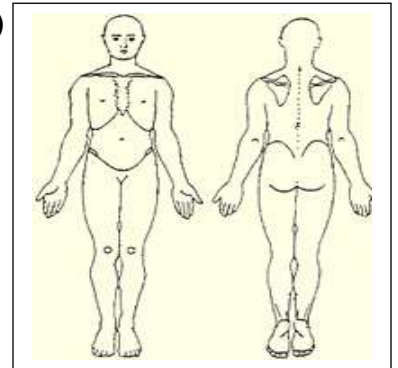
Is the pain there all the time (constant)? Yes ___ No ___

Does the pain move or radiate anywhere? Yes ___ No ___

If yes, describe location of radiation or numbness

Do you have numbness, tingling, or weakness? Yes ___ No ___

If yes, please describe: _____



Please use the body diagram above and *Shade Areas of Pain*

Have you had any changes in your bowel, bladder or sexual function as a result of your symptoms?

Yes ___ No ___ Describe _____

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Where do you currently live (or intend to live) at the conclusion of your episode of therapy?

Private Home Private Apartment Rented Room
 Group Home Assisted Living Skilled Facility Other _____

Who do you live with (or intend to live with) at the conclusion of your episode of therapy?

Live Alone Spouse/Significant other Child/Children
 Other Relative Personal Care Attendant Other _____

Job Description/Social Activities: (physical tasks, amount of sitting, lifting, computer work etc.):

What are your goals for your course of physical therapy? * (Required Response)**

At the present time, would you say your health is excellent, very good, fair, or poor? _____

My signature on this form acknowledges that I agree to bear full financial responsibility for all services provided that may not be covered by my insurance for the following reasons; not a covered benefit, not referred or authorized, or determined not to be eligible for coverage with Washington Hospital Healthcare System. Payment by insurance is not guaranteed until the claim reaches the insurance. **For specific questions regarding your coverage and visit limitations, please reach out to your insurance.** _____ (Initial).

If you need to cancel/reschedule your appointment, please call the office 24 hours ahead of your appointment. If not, you will be charged a **\$25.00 No show fee**.

Patient Signature

Date

Evaluating Therapist Signature

Date

Evaluating Therapist Name (Print)

License Number

Patient's Label

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Medical History

Do you have or did you have any of the following: Please check **Yes** or **No**

| Condition | Yes | No | Indicate Date of Injury/ Onset |
|---------------------|-----|----|--------------------------------|
| | | | |
| Diabetes | | | |
| Heart Disease | | | |
| Heart Attack | | | |
| Stroke | | | |
| High Blood Pressure | | | |
| Heart Surgery | | | |
| Pacemaker | | | |
| Headaches | | | |
| Lung Problems | | | |
| Kidney Problems | | | |
| Nervous Disorder | | | |
| Seizures | | | |
| Pregnancy | | | |
| Sensitivity to Heat | | | |
| Sensitivity to Cold | | | |
| Fractures | | | |
| Other Surgeries | | | |
| Allergies | | | |
| Other (Specify) | | | |
| History of Cancer | | | |
| Smoking | | | |
| Metal Implants | | | |
| | | | |

Reviewed by: _____ Date: _____

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