Baton Rouge Rehab Hospital

PATIENT LABEL

Outpatient Clinical Assessment

Please complete the following questionnaire in order to expedite your evaluation process. Thank You!

Contact Information			
Patient Name:			
➢ Best Contact Number for above: ☐Cell_____	☐ Work_____	☐ Home_____	
Emergency Contact Name:			
➢ Best Contact Number for above: ☐Cell_____	☐ Work_____	☐ Home_____	
Primary Care Physician / Surgeon Name:			
➢ Would you like updates to be sent to this doctor: ☐ Yes ☐ No			
Person Responsible for Scheduling (if other than patient):			
➢ Best Contact Number for above ☐Cell_____	☐ Work_____	☐ Home_____	
Parent/Guardian (if under the age of 18):			
➢ Best Contact Number for above: ☐Cell_____	☐ Work_____	☐ Home_____	
Person to Contact regarding Therapy (if other than patient):			
➢ Best Contact Number for above: ☐Cell_____	☐ Work_____	☐ Home_____	

Social / Other Demographics	
Occupation:	Last Day Worked :
Current Living Situation: ☐ Alone ☐ Assisted Living ☐ Family/Relative ☐ Caregiver ☐ Other:_____	
Is your current living situation different than prior to your illness? ☐ No ☐ Yes; If yes, how: _____	
Do you have any difficulty getting around in your home? ☐ No ☐ Yes; Steps/How many:_____	
Explain any difficulties:	
What is the problem that brings you to therapy:	Date of Onset:
Is your condition due to: ☐ Auto Accident ☐ Fall ☐ Work Injury ☐ Other:	
Is this is a ***workman's comp injury***? ☐ No ☐ Yes; If Yes, where were you when the injury occurred: _____	

Have you had any of the following medical or rehabilitative services for *this* injury/episode?

Test / Service	YES	NO	Results / Outcomes
Physical or Occupational Therapy			
Speech Therapy or Swallow Study			
EMG/NCV			
Myelogram			
CT Scan			
MRI			
X-Ray			
Other:			
Home Health**			

** Please inform us if you are currently receiving Home Health services.

Check the box if you own or require the use of any of the following:

Assistive Devices: ☐ N /A	☐ Standard Walker	☐ Rolling Walker	☐ Hemi Walker	☐ Straight Cane
☐ Large / Small Base Quad Cane	☐ Oxygen	☐ Splint / Brace	☐ Orthotics	☐ Prosthesis
☐ Hearing Aid	☐ Eyeglasses / Contacts	☐ Dentures	☐ Pacemaker	☐ Vascular Stent
☐ PEG	☐ Long Term Venous Access	☐ Other, Please Describe: _____		
Bathroom Accessories: ☐ N /A	☐ Grab Bars	☐ Shower Chair	☐ Tub Bench	☐ Raised Toilet Seat
☐ Bedside Commode	☐ Other, Please Describe: _____			
Other Equipment: ☐ N /A	☐ Hospital Bed	☐ Wheelchair	☐ Cushion	☐ Other

Comments:

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Education / Activities/ Cultural - Religious Beliefs
Level of Education: **Patient**: ☐ 0-7th ☐ 8-12th ☐ College **Caregiver**: ☐ 0-7th ☐ 8-12th ☐ College
Primary Language: **Patient:**_____ **Caregiver:** _____
Barriers to Learning: _____
Motivation / Readiness to Learn:_____ **Preferred Method of Learning**:_____
Leisure Skills/Community Activities:_____
Are there any cultural or religious beliefs you feel may impact your care? If so, please explain:

Do you now or have you ever experienced any of the following?							
	Yes	**No**	**Comments**		**Yes**	**No**	**Comments**
Heart Attack/Surgery				Bowel / Bladder			
Heart Disease				Joint Replacement			
Pacemaker				Psychiatric History			
Circulation Problems				Epilepsy / Seizures			
Numbness/Tingling				Fatigue			
Arthritis				Weight Loss or Gain			
Osteoporosis				Swelling or Edema			
Stroke / TIA				Nausea / Vomiting			
Blood Clot / Emboli				Coughing / Sneezing			
Anemia				Ringing in Ears			
Infectious Disease				Depression			
Diabetes				Swallowing Problems			
Cancer				Severe Headaches			
Asthma				Problems Sleeping			
High Blood Pressure				Blurry/Double Vision			
Dizziness / Fainting				Skin Problems			
Chest Pain				Are you pregnant?			

Please list any previous surgeries or hospitalizations and associated dates:

Have you fallen in the last 3 months? ☐ No ☐ Yes

Are you on any special diet? ☐ No ☐ Yes; If so, what type:_____ Height: Weight:

Have you had 3 episodes of diarrhea in one day within the last week? ☐ No ☐ Yes

Pain Assessment
Pain? ☐ No ☐ Yes **Pain Scale (0-10):** Now _____ Best _____ Worst _____
Frequency: ☐ Less than daily ☐ Daily ☐ Daily-Increases throughout day ☐ Constant ☐ Multiple daily episodes ☐ Night Pain ☐ Disturbed sleep ☐ Other; Please Explain: _____

Current Pain Relief Measures
Relaxation Techniques:
Medication:
Modality / Activity that decreases pain:
Modality / Activity that increases pain:
COMMENTS:

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Current Medications & Herbal Supplements

Please check here if a typed list is included: ☐

List All Allergies (food, etc.)**:**

List Any Adverse Reactions to Medications:

If a list was not provided, please list your current medications below:

DRUG	DOSAGE / FREQUENCY	DRUG	DOSAGE / FREQUENCY
MEDICATION UPDATES *(TO BE COMPLETED BY THERAPIST)*			
DRUG	**DATE /DOSAGE /FREQUENCY**	**DRUG**	**DATE /DOSAGE /FREQUENCY**

Is there anything we need to know that is not covered on this form? ☐ No ☐ Yes, please explain _____

_____

What goals do you hope to accomplish by coming to therapy? _____

_____

_____

COMPLETE THIS SECTION ONLY IF PATIENT IS UNDER 21

What childhood diseases have you had? ☐ Measles ☐ Chicken Pox ☐ Mumps ☐ Rubella

Have you been exposed to any of these in the past three weeks? ☐ No ☐ Yes Explain: _____

_____

PLEASE READ THE FOLLOWING AGREEMENT

In order to reach your optimum rehabilitation, it is essential that you follow your physician's prescribed treatment and the treatment plan established by your therapist. It is equally important that we are aware of any changes in your medical status and/or any changes in the medications you are taking. You are responsible for informing your therapist of any changes so we can maintain an accurate record in the event of an emergency. ***INITIALS _____***

If you must cancel an appointment, please notify us as soon as possible so that we can reschedule your missed appointment within the week. We appreciate notification of cancellations 24 hours prior to scheduled appointments; this allows us to utilize your appointment time for other patients. ***A series of 2 no shows or cancellations may result in a discontinuation of services and notification to your physician of noncompliance. INITIALS_____***

We are obligated to record all cancellations and no shows in your medical record. If you are covered by workman's compensation, we are obligated to report cancelled and "no show" appointments to your insurance carrier. ***INITIALS _____***

_____Patient / caregiver unable to complete form; information reviewed and completed by clinician. _____ *INITIALS*

Signature of Person Completing Form/Initials: _____ Date: _____

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THIS PAGE TO BE COMPLETED BY LICENSED THERAPIST

Neuro/Emotional Status

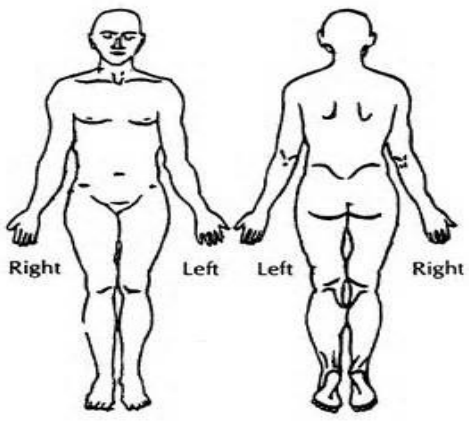
☐ Alert and oriented to time, place, person	☐ Calm and cooperative	☐ Speech clear
☐ Confused	☐ Anxious	☐ Slurred
☐ Lethargic	☐ Agitated	☐ Slow
☐ Restless	☐ Depressed	☐ Aphasic
☐ Hostile	☐ Uncooperative	☐ Difficult to Understand

Other:_____

☐ Skin Intact; ☐ Other: _____

Evidence / Suspicion of abuse or neglect:	☐ No	☐ Yes , Consult Social Worker (SW)	
Emotional status concerns from physical exam?	☐ No	☐ Yes, SW consult requested	☐ Yes, SW consult refused
Have you had changes in sleep patterns or sleep disturbances?	☐ No	☐ Yes, SW consult requested	☐ Yes, SW consult refused
Have you had any significant loss? (flood, move, family member, pet)	☐ No	☐ Yes, SW consult requested	☐ Yes, SW consult refused
Do you have a history of anxiety or depression?	☐ No	☐ Yes, SW consult requested	☐ Yes, SW consult refused

Date/Time referral made: _____ / _____/ _____ Time: _____ Comments: _____



Pain Assessment

0 1 2 3 4 5 6 7 8 9 10

Mark pain symptoms on the body chart using the following symbols:

Sharp Pain: //// Numbness: 0000

Dull Ache: **** Radicular: ↓↓↓

Burning: XXXX

Other Description:_____

_____

Other Pertinent Information:

I have reviewed the Patient Information Record with patient/family prior to initiating assessment/evaluation:

Clinician Signature / Title / Initials: _____ Date/Time: _____

Clinician Signature / Title / Initials: _____ Date/Time: _____

Clinician Signature / Title / Initials: _____ Date/Time: _____

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