TO BE COMPLETED BY PATIENT OR FAMILY MEMBER ON BEHALF OF PATIENT

Date: ______________________

1. Do you understand written English? □ Yes □ No
2. Do you understand spoken English? □ Yes □ No
3. Do you have visual problems that impair your ability to read? □ Yes □ No
4. Do you need an interpreter? □ Yes □ No
5. Do you have a hearing problem? □ Yes □ No
6. Are you or a family member being harmed or not taken care of? □ Yes □ No
7. Are there any customs/religious beliefs/rituals/wishes that might affect your care? ______________________
   ______________________
8. What is the reason for your visit today? ______________________
   ______________________
9. When did this problem begin? ______________________
10. Have you seen, or are you currently seeing anyone else for this problem(s): □ Yes □ No
    If Yes, who? (Check all that apply)
    □ Another Therapist □ OB/GYN
    □ Acupuncturist □ Orthopaedist
    □ Cardiologist □ Osteopath
    □ Chiropractor □ Pain Specialist
    □ Dentist □ Pediatrician
    □ ENT □ Ophthalmologist
    □ Family MD □ Rheumatologist
    □ Massage Therapist □ Neurologist
    □ Neuropsychologist □ Podiatrist
    □ Plastic Surgeon □ Dermatologist
    □ Physiatrist □ Other: ______________________
11. Have you ever had this problem(s) before? □ Yes □ No
    If Yes, what did you do for it? ______________________
    ______________________
12. Did the problem(s) get better? □ Yes □ No
13. How are you taking care of the problem(s) now? ______________________
    ______________________
14. When is your next appointment with the physician who referred you to us? ______________________
15. Have you ever been told that you have:
    (Check all that apply)
    □ Allergies  □ Low Blood Sugar
    □ Arthritis  □ Hypoglycemia
    □ Blood Disorders  □ Liver Problems
    □ Broken Bones/ Fractures  □ Lung Problems
    □ Cerebral Palsy  □ Multiple Sclerosis
    □ Circulation/Vascular Problems  □ Muscular Dystrophy
    □ Chemical Dependency  □ Osteoporosis
    □ Depression  □ Parkinson’s Disease
    □ Developmental or Growth Problems  □ Repeated Infections
    □ Diabetes/High Blood Sugar  □ Seizures/Epilepsy
    □ Head Injury  □ Skin Diseases
    □ Heart Problems  □ Stroke
    □ High Blood Pressure  □ Thyroid Problems
    □ Infectious Disease  □ Ulcers/Stomach Problems
    □ (such as Tuberculosis, Hepatitis) □ Mental Health Issues
    □ Kidney Problems □ Reflux
    □ Other: ______________________
16. List any surgeries that you have had:
    Surgery: Date: ______________________
    ______________________
    ______________________
    ______________________
    ______________________
17. Do you have a shunt? □ Yes □ No
18. Do you have a pacemaker? □ Yes □ No
19. Are you pregnant? □ Yes □ No □ Don’t Know
20. Have you had any cancer? □ Yes □ No
21. Do you have a latex allergy? □ Yes □ No
22. Do you have skin sensitivities or allergies? (i.e., Tape) □ Yes □ No
   If Yes, give details: ______________________
   ______________________
   ______________________
23. Within the past year, have you had any of the following? (Check all that apply.)
- Bowel Problems
- Chest Pain
- Coordination Problem
- Cough
- Difficulty Sleeping
- Difficulty Swallowing
- Difficulty Walking
- Dizziness or Blackouts
- Fever/Chills/Sweats
- Headaches
- Arms/Legs
- Hearing Problems
- Heart Palpitations
- Weight Loss/Gain
- Other:

24. List all current prescriptions, over-the-counter medications and herbal supplements you are taking: (Use back if needed)

25. Do you have any difficulty taking medications as prescribed?  Yes  No
If Yes, give details:

26. List any drug or food allergies: (Sulfa, shellfish, iodine, IV dye, etc.)

28. With whom do you live? (Check all that apply)
- Alone
- Partner/Spouse
- Child(ren)
- Foster Care
- Parent(s)
- Grandparent(s)
- Other:

29. Have you had any major life changes during the past year that would affect your care?  Yes  No
If Yes, please explain:

30. Check all diagnostic testing already performed for this diagnosis, if any:
- Arterial Studies
- MRI
- Audiogram
- Tissue Biopsy
- Bone Scan
- Venous Doppler
- CT Scan
- Wound Cultures
- EMG
- X-Rays
- ENG
- Other:

31. If home instructions are prescribed, how do you learn them best? (Check all that apply)
- Printed Material
- Verbal Instructions
- Demonstration
- Pictures
- Trial and Error
- Other:

32. Do you have pain?  Yes  No
If Yes, where?

REHABILITATION SERVICES – GENERAL INTAKE FORM
PAIN/MEDICAL QUESTIONNAIRE (Page 2 of 2)

For Staff Use Only

Name:
Hospital #:
Physician:

Testing:

Patient/Family Education:

Pain:

As of what date?
REGISTRATION
REHABILITATION SERVICES
PATIENT INFORMATION

Patient Name ________________________________________________________
Date of Birth _________________________ Social Security # _____ - ____ - _____
Home Address _______________________________________________________
City _______________________ State _________________ Zip Code _________
Home Phone ____________________ Cell Phone __________________________
Marital Status (please circle)            Single        Married         Divorced        Widowed
Patient Employer Name ____________________       Full or Part Time ___________
Work Phone ____________________    Email Address _______________________

Person Responsible for payment, if not patient:
Name _______________________________   Date of Birth ___________________

Patient Insurance _________________________  Policy # ____________________

Was this an accident? (please circle)   YES   NO     If yes, please complete the following:
Date of Accident ___________________  Time of Accident ____________________
Location of Accident __________________________________________________

Emergency Contact Name ______________________  Relation _______________
Date of Birth ________________   Home Phone ____________ Cell Phone __________
1. At what age did your child:
   Hold his/her head up?
   Roll over?
   Sit alone?
   Crawl?
   Walk?
   Run?

2. Was your child enrolled in First Steps or an early intervention therapy program?  
   Yes  No
   If Yes, check the therapies your child has received:
   - Physical Therapy
   - Occupational Therapy
   - Speech Therapy
   - Developmental Therapy
   If Yes, when was your child discharged and why?

3. Does your child currently attend other therapies?  
   Yes  No
   If Yes, check the therapies your child has received:
   - Hippotherapy (Horse Therapy)
   - Aquatic Therapy
   - School Therapy (OT, PT, Speech)
   - Occupational Therapy
   - Speech Therapy
   - Other
   If Yes, how often?

4. Does your child wear a brace/splints?  
   Yes  No
   If Yes, what kind of brace/splints?
   How old are the braces/splints?

5. Has your child ever received Botox injections?  
   Yes  No
   If Yes, at what facility/MD?
   Date of last injection:
   To which muscles?

6. Has your child ever had serial casting?  
   Yes  No
   If Yes, at what facility?
   When was the serial casting?
   What was serial casted?

7. Does your child use any equipment?  
   Yes  No
   If Yes, please check any that apply:
   - Wheelchair (manual / power)
   - Walker
   - Gait trainer
   - Stander
   - Crutches
   - Other

Patient/Guardian Signature: ________________________________ Date: ______________

Reviewed By/Therapist Signature: ____________________________ Date: ______________
Thank you for choosing our Rehabilitation Services.

To help us better serve you:

GENERAL POLICY

- Return appointments are scheduled for 30 – 60 minutes. To allow optimal treatment time, please arrive 5 - 10 minutes before your scheduled appointment to change clothes, use the bathroom, etc. If you arrive 15 minutes late for a scheduled appointment, you may have to:
  1. Wait to be seen by your therapist,
  2. Receive an abbreviated treatment,
  3. Be seen by another therapist, or
  4. Reschedule your appointment.
- Allow plenty of travel and parking time.
- If you are receiving Physical or Occupational therapy, please wear or bring appropriate clothing for the type of treatment you are receiving. Patient gowns are provided.

CANCELLATION

- 24 hour notification is requested to cancel an appointment. Please call ____________________.
- If you miss an appointment, please call to confirm your next appointment time or to reschedule.
- Your consistent attendance and participation is imperative to your progress. Therefore, if the recommended plan of care is not followed and/or you are not making progress in your treatment plan, you will be discharged and your physician notified. If this occurs, a new referral for therapy will be necessary to set up a new therapy schedule.

ILLNESS

- Appointments should be cancelled if the patient has a fever of 100 degrees or above, vomited, or has been exposed to or diagnosed with an illness in the past 24 hours.
- If you have any questions about your care, please discuss with your therapist. We want to assist you with your rehabilitation. A supervisor may be contacted if you have further concerns.

BILLING

- If you have questions regarding the billing of our service, please call Patient Financial Services General Information at (317) 962-8661 or (800) 552-6871 Indiana only.
- If you need to obtain a copy of your medical records, contact Health Information Management (Medical Records) at 962-8911 or fax your request to 962-6285.
- To find out about insurance coverage for therapy services, please contact your insurance company.

I have read and agree to follow the above policy.

____________________________________  ______________________
Patient Signature                              Date