First State Rehab At Home

Client Information

Name: ____

Social Security Number:________________________________

Driver's License Number: ______________________________

Date Of Birth: ___/___/______ Age:______ Male __ Female__

Height:_____ft_____inches Weight: _______lbs

Permanent Address: ___________________________________

City:__________________________State:____Zip:________

Home Phone:___________________Cell:________________

e-mail:____

Occupation:____

Place of employment:___________________________________

Phone Number: ____________________________________

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name:__________________________Relation:_____________

Phone: ____

Referring Physician:______________________________________

Primary Care Physician:___________________________________

Why are you seeking Physical Therapy:

____

____

What happened?____

When did it happen/start?___________________________________

Have you had this problem before?__Yes__No

If yes, when?_____________________

Have you had Physical Therapy for this problem before?__Yes__No

Are You currently seeing anyone else for this problem?__Yes__No

If yes, who?____

Do you have difficulty with any of the following? (Check all that appl)

__Bed Mobility	__Gait	__Up or Down Stairs

__Transfers	__On level ground	__On uneven terrain

__Bathing	__Grooming	__Shopping

__Cooking	__Home chores	__Driving

__Sleeping	__Standing from a chair	__Sports

__Hobbies	__Use a phone	__Reach a high shelf

__Writing a letter	__Standing >15 minutes	__Sitting >15 minutes

Exercise / Activities

Do you exercise beyond your normal daily activities and chores?
__Yes__No

If yes, what do you do?____

How many days per week?____

Are there social or recreational activities you
enjoy?____

With whom do you live? (Check all that apply):

__Alone __Spouse __Child/Children __Other

Current Employment (check all that apply):

__Working full time __Working part time __Retired

__Student __Unemployed __Other

Living Environment (Check all that apply):

__Stairs __Ramps __Elevator

__Assistive devices (grab bars, etc)

Do you use any of the following? (check all that apply)

__Cane __Walker __Manual Wheelchair __Power Wheelchair

__Power Scooter __Glasses __Contacts __Other________

Past Medical History (Check all that apply)

__Arthritis __Broken Bones __Osteoporosis

__Blood Disorders __Circulation Problems __Lung Problems

__Heart Problems __High Blood Pressure __Stroke

__Diabetes __Low Blood Sugar __Head Injury

__Multiple Sclerosis __Muscular Dystrophy __Polio

__Parkinson Disease __Seizures/epilepsy __Allergies

__Thyroid Problems __Developmental Problems __Infectious Disease

__Cancer __Kidney Problems __Repeated Infections

__Depression __Skin Diseases __Ulcers/stomach

__Other____

Within the past year, have you had any of the following symptoms?

__Chest Pain __Heart Palpitations __Coughs

__Shortness of breath __Dizziness/Blackouts __Headaches

__Loss of Balance __Coordination Problems __Difficulty Walking

__Pain at night __Joint Pain or Swelling __Difficulty Sleeping

__Loss of Appetite __Nausea/Vomiting __Difficulty Swallowing

__Bowel Problems __Weight Loss/Gain __Urinary Problems

__Fever/Chills/Sweats __Hearing Problems __Vision Problems

__Weakness in Arms/Legs __Other____________

Prescription Medications

Please list all medications you currently take:

____

____

____

____

Non-prescription Medications and Vitamins/herbs:

____

____

____

____

List all surgeries, including dates:

____

____

____

PLEASE DO NOT WRITE ON THIS PAGE

Client Name______________________________ Date_______________________

BP:__________/___________ HR:_________ Resp:_______ PO2:_________

Height:_______ft_________in Weight:_____________lbs

Client Name:____

Primary Insurance Information:

Policy Company Name:____________________________________

Address:____

____

Contact information:

____

____

Policy Number: ____

Policy Holder, Name and DOB and SS#, if not the client**:**____

____

Secondary Insurance:

Policy Company Name:____________________________________

Address:____

____

Contact information:

____

____

Policy Number: ____

Policy Holder, Name and DOB and SS#, if not the client**:**____

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