

COOLEY DICKINSON HOSPITAL
ADULT OUTPATIENT INTAKE (OT-PT-SP)

Rehabilitation Services
CDH 174 Rev. 1/09

Name _____
patient label

Today's Date _____ Patient's age: _____ Date of birth: _____
Address _____
Home Phone _____ Work Phone _____ Cell Phone _____
Emergency Contact _____ Relation _____ Phone _____
Primary Language: English Spanish Other: _____
How do you best learn? Pictures Observation Reading Doing other _____

Have you ever had therapy before? No Yes (OT PT Speech) **When?:** _____
Why?: _____ **Where?:** _____

Current Condition(s)/Chief Complaint(s):

Who referred you for therapy today? _____ Primary Physician: _____

Describe the problem(s) for which you seek therapy _____

When did the problem(s) begin (date): _____
What happened? _____

Have you ever had the problem(s) before? No Yes
What did you do for the problem(s)? _____
Did the problem(s) get better? No Yes
How long did the problem(s) last? _____
What makes the problem(s) better? _____
What makes the problem(s) worse? _____

Are you currently receiving ANY services at home? No Yes (circle): OT, PT, Speech, Nurse, Home Health Aide
What agency? _____

In this past year, have you received Rehab Services from another provider for the condition described above?
If yes, how many visits and from whom? No Yes # Visits: _____ When: _____
Provider: _____

Medical/Surgical History: (Please check off any of the following conditions you have experienced):

- Allergies: Food Latex Other: _____ Reaction (circle): Itching, Rash, Nausea, Shortness of Breath, Swelling
- Anxiety Diabetes Infectious Diseases
- Arthritis/Osteoporosis Disturbed Sleep Persistent Cough/Fever
- Blackouts/Dizziness/Headaches Hearing Impairment Previous Fractures
- Blood Clot/DVT Heart/Lung Disease Seizures
- Cancer High Blood Pressure Stroke
- Depression High Cholesterol Unexplained Weight Loss
- Pregnant currently Pacemaker Visual Impairment
- Other Medical: _____

Other Surgery (ies): _____

Other Clinical Tests:

Within the past year, have you had any of the following tests? (Please list where/when the test was performed for each)

X-ray _____

CT-Scan _____

MRI _____

Other _____

School: _____ grade Leisure interests: _____

Employment/Occupation: _____ Employer _____

Social/Health Status:

Are you currently smoking? No Yes

Do you drink alcoholic beverages? No Yes

Do you regularly exercise beyond daily activities and chores? No Yes: amount: _____

What are your goals for therapy? _____

Due to the increase in domestic violence, we ask all adult patients:

“Are you being hurt, hit, or frightened by anyone in your home or life?” No Yes

If you answered “yes”, would you like assistance in this situation? No Yes

FALLS PROTOCOL

1. Do you need assistance walking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you had a fall in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you feeling dizzy or lightheaded right now?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Therapist initiates PROTOCOL if “yes” to any of above questions (✓ interventions used).	
<input type="checkbox"/> Patient/family education of Protocol <input type="checkbox"/> Assist to and from waiting area. <input type="checkbox"/> Assist to bathroom when needed. <input type="checkbox"/> Assistive devices normally used by patient will be available for ambulation in the department (cane, wheeled walker, wheelchair, etc.). <input type="checkbox"/> Falling Star posted	
Therapist initials:	Date:

I received and understand the Rehab Dept. Cancellation Policy, & have provided the above information to the best of my ability:

Patient signature: _____ **date:** _____