Kessler
INSTITUTE FOR REHABILITATION
A Division of Select Medical

Outpatient Medical History / Screening Form - pg.1 of 2

To be completed by the patient

Patient Name:_____ Spoken Languages:_____

Preferred language to receive healthcare information *for patient* :_____

Preferred language to receive healthcare information *for legal guardian / Healthcare Proxy* : _____

Emergency Contact:_____ Telephone # :_____

Family Physician/Internist:_____ Telephone # :_____

Religious / Cultural Needs: NO ☐ YES ☐ Please Explain:_____

Special Learning Needs: NO ☐ YES ☐ Please Explain:_____

Hearing Difficulty: NO ☐ YES ☐ Speaking / Communication Difficulty: NO ☐ YES ☐

Why are you here?_____ Date of Injury

Medical Information:

	YES	NO	Family History		YES	NO
History of Diabetes	☐	☐	☐ **Y**	☐ **N**	Diminished Sensation / Numbness	☐	☐
Hypertension (high blood pressure)	☐	☐	☐	☐	Skin Sensitivities:	☐	☐
Heart Attack	☐	☐	☐	☐	Latex ☐ / Adhesives ☐ / Temperature ☐		
Heart Disease	☐	☐	☐	☐	History of pressure sores	☐	☐
High Cholesterol	☐	☐	☐	☐	Pacemaker / Defibrillator	☐	☐
Smoking	☐	☐			Bleeding / Bruising (recent history)	☐	☐
Chest Pain / Angina	☐	☐			Hypoglycemia	☐	☐
Light-Headedness / Dizziness / Fainting	☐	☐			Active seizure disorder	☐	☐
Hypotension (low blood pressure)	☐	☐			Dementia / Alzheimer's	☐	☐
Shortness of Breath	☐	☐			Kidney Disease	☐	☐
Ankle Swelling	☐	☐			Asthma	☐	☐
Night Coughing	☐	☐			* Always have inhaler with you	☐	☐
Cancer / Tumors / Growths	☐	☐	☐	☐	Lung Disease / Emphysema / COPD	☐	☐
*Radiation / Chemotherapy Treatment	☐	☐			* Oxygen use	☐	☐
Osteoporosis	☐	☐	☐	☐	Are You Pregnant?	☐	☐
Osteoarthritis	☐	☐	☐	☐			
Rheumatoid Arthritis	☐	☐	☐	☐	In the past month, have you frequently been bothered by feeling down, depressed or hopeless?	☐	☐
Rheumatic Disease	☐	☐	☐	☐			
Have you had / have a: Stroke	☐	☐	☐	☐	In the past month, have you frequently been bothered by having little interest in things or have you lost pleasure in doing	☐	☐
Multiple Sclerosis	☐	☐	☐	☐			
Brain Injury	☐	☐					
Spinal Cord Injury	☐	☐					
Fractures	☐	☐			Other	☐	☐
DATE:_____ AREA:_____					_____		
DATE:_____ AREA:_____							

In the past three months have you experienced:		
Changes or difficulty with Bowel	☐	☐
Changes or difficulty with Bladder	☐	☐
Night Sweats	☐	☐
Fever	☐	☐

Are you in pain?

Location of pain_____

If you answered yes to any of the above:

Are you under the care of an MD for these conditions?	YES	NO
	☐	☐

Allergies: _____

_____

Surgery(s) within last 3 months - Include Dates: _____

What are your Rehabilitation goals?:_____

Medical Information:

If you need information regarding Advanced Directives, please contact the site Admission/Office Assistant. Advanced Directives are not honored in the Outpatient Setting.

FALL RISK ASSESSMENT*:

	YES	NO
Have you fallen within the last year? If so, how many times? _____	☐	☐
Have any of these falls resulted in an injury within the last year?	☐	☐
Are you afraid of falling?	☐	☐
Have you recently felt unsteady on your feet or in your wheelchair?	☐	☐
Do you experience dizziness or vertigo?	☐	☐
Do you have vision problems that are not corrected by glasses?	☐	☐
Do you use sedatives that affect your level of alertness during the day?	☐	☐
Do you have memory / cognitive difficulties?	☐	☐
Do you have a lower extremity disability that affects walking?	☐	☐

AS PER CMS FALL SCREENING CRITERIA

***Patient is considered a fall risk if patient has fallen two or more times in the past year**

***Patient is considered a fall risk if patient has fallen one time with resulting injury in the past year**

NUTRITIONAL SCREENING

	YES	NO
Unexplained weight loss? (>5% in last 30 days)	☐	☐
Recent loss of appetite/aversion to food?	☐	☐
Do you have difficulty swallowing?	☐	☐
Decrease in food intake?(<50% for 3 days or more)	☐	☐
Are you under the care of a MD for these conditions?	☐	☐

CURRENT MEDICATION (List below)

I provided separate list of medications: ☐

I am currently not taking any over the counter or prescribed medications / herbals: ☐

Are all meds prescribed by a physician? Yes ☐ NO ☐

*__FALL RISK__ - *Patient is considered a fall risk if they answer yes to three or more fall risk assessment questions, if they meet CMS screening criteria for fall risk, or if therapist judgment indicates. Clinician should refer to the Fall Prevention Policy in the OP KRC P&P manual (PC OP 1018).*

Please inform your therapist of any changes in medications, medical conditions or surgeries so this summary list can be updated as you progress in your treatment.

PATIENT SIGNATURE:_____**DATE:**_____

UPDATES:

Please list changes to Medication:

Please list changes to medical condition/surgeries:

PATIENT SIGNATURE:_____**NEW DATE:**_____

This information will be used as a guide to your treatment plan. If you need any medical follow-up, please contact your physician.

To be completed by evaluating Therapist

Patient has been identified as a fall risk : yes no

Patient has been identified as a nutrition risk : yes no (If yes, notify MD)

Patient would benefit from a Social Services referral: yes no (yes if therapist feels patient life is threatened, or if patient is a threat to others)

Therapist Signature:	**Date:**	**Time:**
Therapist Signature:	**Date:**	**Time:**
Therapist Signature:	**Date:**	**Time:**
Therapist Signature:	**Date:**	**Time:**
Therapist Signature:	**Date:**	**Time:**

(Therapist has reviewed medical history form with patient)

Medical Screening Form (Optional)

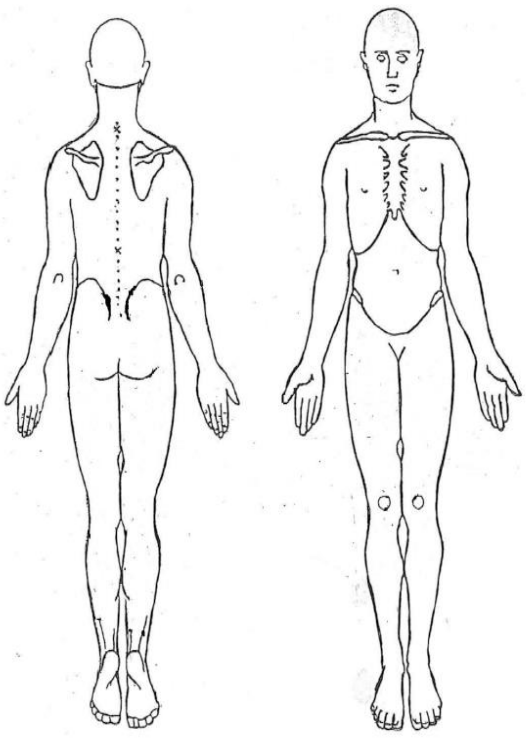
Name:_____ Date:_____

I HAVE PAIN: YES_____ NO_____ (If no skip to "Patient Specific Functional Scale" below)

Please use the diagram below to indicate where you feel symptoms right now.

Use the key below to indicate the different types of symptoms:

KEY: Pins & Needles = oooooo Stabbing = //////////
Burning = XXXXXX Deep Ache = ZZZZZZ



Please mark your ***best (B), current (C), and worst (W)*** level of pain or symptom on the following line:

_____

0 1 2 3 4 5 6 7 8 9 10

(**0** = none →**10** = worst imaginable. Indicate level for each with B, C, and W)

1. What makes your pain or symptom worse?

_____

_____

2. What makes your pain or symptom better?

_____

_____

3. Are your symptoms: (check one)
☐Getting worse; ☐The same; ☐Improving

4. How are you able to sleep at night? (check one)
☐Fine; ☐Moderate Difficulty ; ☐Only with Medication

5. Do you have pain at night? ☐Yes … ☐ No

6. When (date) did your problem begin? _____

7. Have you been treated for this before? ☐Yes … ☐No

When? _____

How? _____

PATIENT SPECIFIC FUNCTIONAL SCALE :

(*First Time Use for This Case)* Identify up to three (3) important activities that you are unable to do or are having difficulty with as a result of your medical condition. Using the Scale below indicate your ability to perform these activities today.

(***0** = unable to perform →**10** = as able as pre-injury)*

1. Activity_____ 0 1 2 3 4 5 6 7 8 9 10

2. Activity_____ 0 1 2 3 4 5 6 7 8 9 10

3. Activity _____ 0 1 2 3 4 5 6 7 8 9 10