Outpatient Therapy Intake

Emergency Contact:_____ **Emergency contact's phone #:**_____
Reason for today's visit:_____
When did your problem start? _____
Has your doctor given you any restrictions? _____
What are your goals for therapy? _____
Have you had previous treatment for this problem? □ PT □ OT □ Speech □ Other_____

Tests performed? □ X-Ray □ MRI □ CT Scan □ Other_____

Medical History: Please check if you have had problems with the following:

□ Anemia	□ Depression/ mental health	□ Gynecologic	□ Lung /breathing	□ Seizures
□ Arthritis	□ Diabetes	□ Headaches/ migraines	□ Memory	□ Skin
□ Back trouble	□ Drinking or drugs	□ Hearing	□ MRSA	□ Speech
□ Balance	□ Ear, nose, throat, mouth	□ Heart	□ Muscle	□ Spinal stenosis
□ Bleeding	□ Fainting	□ HIV/AIDS	□ Neuropathy	□ Stomach ulcers
□ Blood clots	□ Falls	□ Infection, recent	□ Night sweats, recent	□ Stroke
□ Blood pressure	□ Fever, recent	□ Intestinal	□ Open wound	□ Swallowing
□ Blood transfusion	□ Fractures	□ Joint(s)	□ Osteoporosis	□ Thyroid
□ Bowel/bladder (recent changes)	□ Gallstones	□ Kidney	□ Pancreatitis	□ Vision
□ Brain injury		□ Liver	□ Perineal numbness	□ Weight change, (unexplained)
□ Cancer_____			□ Prostate	

Other, please specify:_____
_____
Are you pregnant?_____ Do you have a pacemaker or implanted stimulator?_____

Surgeries/Hospitalizations: (Please list type of surgery and date)_____
_____
_____

List current medications:_____
_____
_____
List allergies (food/medication):_____
Do you have a Latex/Rubber sensitivity?_____
If you have pain: Circle the number which best describes the intensity of your pain

0	1	2	3	4	5	6	7	8	9	10
No Pain										Excruciating

Please complete on back

Carolinas HealthCare System
Outpatient Therapy Intake

Facility:_____
Location: □ Inpatient □ Outpatient □ Rehab

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Name

U/MR #

Physician

Social History:

Living Situation: □ Alone □ With family □ With friends □ Other_____

Do you have difficulty getting in and out of your house by yourself?	□ Yes	□ No
Have you ever been afraid of, hurt, or forced by anyone against your will?	□ Yes	□ No
Are you having difficulty driving?	□ Yes	□ No
Is transportation a problem?	□ Yes	□ No
Do you have unmet needs for basic food, shelter and medication?	□ Yes	□ No
Have you had major life changes or events that may impact your therapy?	□ Yes	□ No
During the past year, have you often been bothered by feeling down, depressed, or hopeless?	□ Yes	□ No
During the past month, have you often been bothered by little interest or pleasure in doing things?	□ Yes	□ No
Are you currently using any medical equipment?	□ Yes	□ No

Describe_____

Have you fallen in the past year?	□ Yes	□ No
If yes: How many times have you fallen? _____		
Did you injure yourself when you fell?	□ Yes	□ No

Please describe any injury from falling:_____

How, when and where did you fall? _____

_____

Occupation_____

Has your job recently changed?	□ Yes	□ No

Functional Status: Your therapist will need the following information to support the need for skilled therapy.

Please check all areas where you are now having more difficulty due to your present injury/illness:

□ Sleeping	□ Cooking	□ Sit to stand	□ Paying attention	□ Managing medications
□ Eating	□ Cleaning	□ Standing	□ Reading	□ Managing schedule
□ Swallowing	□ Laundry	□ Walking	□ Paying bills	□ Computer/phone use
□ Talking	□ Driving	□ Climbing stairs	□ Writing	□ Other:(specify)
□ Bathing	□ Grocery shopping	□ Lifting	□ Remembering	
□ Dressing	□ Caregiving	□ Working	□ Understanding	
□ Grooming	□ Lawn care/gardening	□ Recreation/hobbies		

Comments regarding your functional level: _____

_____

At the present time would you say your overall health is: □ **Excellent** □ **Very Good** □ **Fair** □ **Poor**

Below This Line For Clinician Use Only

Follow – Up Recommendations: □ Social Work Assessment □ Nutrition Consult □ Balance Assessment

□ Other:_____

This intake form was reviewed by:_____ Date / Time:_____

Clinician Signature

Carolinas HealthCare System
Outpatient Therapy Intake

Facility:_____

Location: □ Inpatient □ Outpatient □ Rehab

Name

U/MR #

Physician