REX OUTPATIENT REHABILITATION of
☐ Raleigh ☐Cary ☐ Garner ☐Wakefield
A Department of Rex Hospital

Patient Name:
Registration #:

PATIENT INTAKE FORM

Instructions: Fill in or check the requested information

Name: _____ DOB: _____ Age: _____TODAY's Date:_____

Reason for Referral/Diagnosis: _____

Occupation/Employer: _____
Were you injured on the job? ☐No ☐Yes (Date):_____
Currently Working: ☐Full Time ☐Part Time ☐Light Duty ☐No
Any MD. Restrictions: Yes ☐ No ☐

If so, what restrictions? _____

Have you received physical therapy or other treatment for this injury before? ☐ Yes ☐ No

If so, briefly describe the treatment you received: _____

Are you currently receiving any type of Home Health Services? Yes ☐ No ☐

How long has this pain/problem been present? _____

How did it occur? _____

_____

Do you have a history of this problem? ☐ Yes ☐ No If so, how long? _____

Please check if applicable **TO YOU**:

☐ Diabetes	☐ High blood pressure	☐ Extreme Fatigue
☐ Cardiac problems	☐ Arthritis (Rheumatoid/Osteo)	☐ # of Falls past year: _____
☐ Stroke	☐ Cancer (please describe):	☐ Drastic ***Unexplained*** Weight Loss/Gain
☐ Long Term Steroid Use	☐ Night sweats	☐ Hiatal Hernia/GI Reflux
☐ Osteoporosis/Osteopenia	☐ Currently Pregnant	☐ Bowel/Bladder Changes
☐ Pacemaker	☐ Metal/Electric implants	☐ Depression
☐ Tuberculosis	☐ MRSA	

☐Fractures (please list) _____

Other _____

Allergies: Latex: Yes/No Medications:_____ Other:_____
Please list any surgical procedures you've had and dates :_____

_____

Please list all medications you are currently taking: _____

_____

Are You Currently Taking: ☐Blood Thinners ☐Steroids ☐ Beta Blockers ? **OVER**

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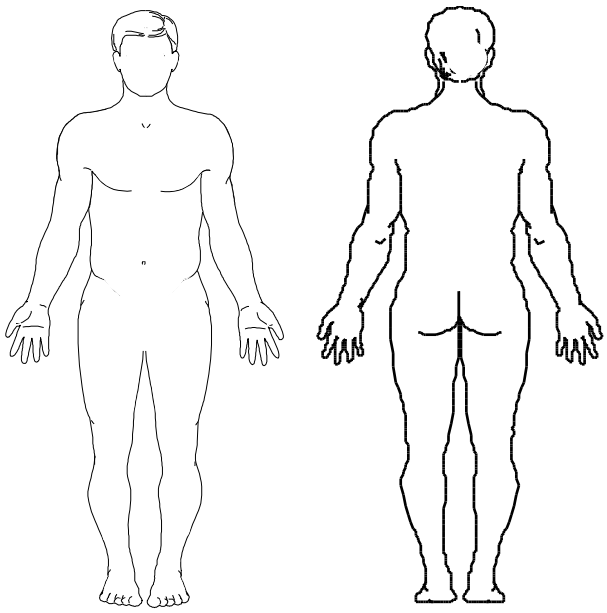

Where is your pain? (Shade in areas of pain on the body diagrams)

Describe your pain (check all that apply):

☐ Dull ☐ Burning ☐ Constant
☐ Achy ☐ Stabbing ☐ Intermittent
☐ Sharp ☐ Radiating ☐ Throb
☐ Numb/tingling
☐ Other:

Rate your pain on a 0-10 scale, 10 being emergency room pain:

Worst _____ Current _____ Least _____

What makes your pain worse? _____

What makes your pain better? _____

Have you had any of these tests for this problem? ☐ X-rays ☐ MRI ☐ CT scan
☐ Other (describe): _____

If so, what were the results? _____

Are you or were you on a regular exercise program such as walking, aerobics, etc? ☐ Yes ☐ No

Please describe: _____

Other hobbies or activities, such as gardening, housework, etc? Yes ☐ No ☐

Please describe: _____

During the last 24 hours, how much has the pain interfered with your ability to perform your desired daily activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Please check any functional activities with which you are having trouble:

☐ walking ☐ going up/down stairs ☐ combing/washing hair
☐ standing ☐ sleeping ☐ lifting
☐ sitting ☐ going to/from sit/stand ☐ housework
☐ dressing ☐ driving ☐ working
☐ Other: _____

Any other health concerns that you feel we should know about?

_____

_____

_____

I have reviewed this information with the patient. _____ _____
Therapist Signature Date