PATIENT MEDICAL HISTORY

Name:_____ **Age**:_____
Phone #: _____ **Cell Phone: _____**

Date of next doctor's appointment_____
Are you presently working? __ Yes __ No; If Yes __ Light/Modified Duty __ Regular Duty

What area is the problem? __Head, __Neck, __Back, __Shoulder, __Elbow, __Wrist, __Hand, __Hip, __Knee, __Ankle, __Foot, __Other_____ (___ Right ___ Left).
How did you injure yourself?
_____
Date of injury? _____ **Was the onset**: __ Gradual or __ Sudden?
If this is a longstanding problem, when did it become worse: _____
Are you currently being seen by ___ Physical/Occupational Therapist ___Chiropractor?

Have you recently had: Xrays _____, MRI _____, Cat Scan _____, Bone Scan _____, other _____.
Have you been hospitalized for this problem? __Yes __No If yes, give dates: _____

Please list any surgeries or conditions for which you have been hospitalized:

Date	Reason	Date	Reason
_____		_____	
_____		_____	

Do you require any special assistance or modifications in your medical care because of your primary language, religious beliefs or other emotional or personal preferences? __ Yes __ No

Have you ever been diagnosed with any of the following?

Yes	No		Yes	No		Yes	No	
__	__	Seizures	__	__	High Blood Pressure	__	__	Elevated Cholesterol
__	__	Cancer	__	__	Respiratory Problems	__	__	Diabetes
__	__	Tuberculosis	__	__	GI Problems	__	__	Do you smoke
__	__	Hepatitis	__	__	Rheumatoid Arthritis	__	__	Do you exercise regularly
__	__	Kidney Disease	__	__	Other Arthritic Conditions	__	__	Other _____
__	__	Depression	__	__	Chemical Dependency	__	__	Allergies Drug/other

__ __ Is there a history of Heart Disease or Surgery in yourself or your family?

Are you pregnant? __ Yes __ No
Have you ever had a fracture or dislocation? __ Yes __ No
If yes, which body part: _____ Date:_____
Do you have any metals or plastic in your body? ___ Yes ___ No. If yes, where: _____
List any current medications or recent injections: _____

Signature: _____ Date: _____**Relationship if other than patient**: _____
Reviewed by therapist: _____ Date: _____ **Time:** _____

Medication Reconciliation for Rehabilitation Patients

The rehabilitation staff at Central Carolina Hospital is committed to providing top quality care.

We need an accurate and complete list of your current prescriptions, over- the-counter medications and herbal preparations in order to best serve you during therapy as well as in the event of transfer to another service or department.

Please take a few minutes to complete this form. Our staff can assist you if you prefer to bring your medication bottles. **The pharmacy staff at CCH is available to answer any questions you have about your medication.**

Medication	Dose	Quantity	Frequency	Last taken	Comments

I would like to have a pharmacist discuss my medications with me: no yes
Further instruction:_____

I understand this information is essential for receiving quality care in a coordinated, team approach. I have been advised to report any changes in my medications to the rehabilitation staff.

_____ _____ _____ _____ _____
Signature of Patient Date Signature of Therapist Date Time

Changes, new or discontinued medications. Therapists please initial and date.

Rehabilitation Department

Patient Name:_____

CONSENT TO EVALUATE/ INITIATE TREATMENT

I do hereby consent to the evaluation and initiation of treatment by Central Carolina Hospital Rehabilitation Department.

Patient/Responsible Party Signature: _____ Date: _____

Witness Signature: _____ Date: _____

INFORMED CONSENT (**AFTER EVALUATION**)

I do hereby consent to further treatment by Central Carolina Rehabilitation staff. The therapist has reviewed my diagnosis with me, discussed the outcome of my evaluation, the plan for my treatment and the benefits expected, associated risks and alternatives, and has fully answered all of my questions. I understand that I have the right to privacy, confidentiality, and safety. I agree with the plan for my treatment. I realize that I may opt to withdraw my consent for further treatment at any time.

Patient Signature: _____ Date:_____

Therapist Signature: _____ Date: _____

Central Carolina Hospital

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Ambulatory Care Services Fall Risk Tool

Patient Name: _____ Date:_____

The Representative will ask the following questions regarding the patient:

Please answer the questions below	Yes	No
Do you have trouble standing?		
Do you have trouble walking on your own?		
Do you have trouble dressing or undressing yourself?		
Do you currently use a wheelchair, walker, cane or anything else to help you walk? If you answered "Yes", what device do you have? _____		
Have you fallen within the last 12 months?		

If patient answers yes to any of the above questions please apply a **yellow armband** on patient and provide safe transport to treatment area.

Employee Signature: _____ Date: _____

Ambulatory Care Services Fall Risk Tool

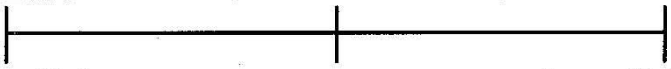
«PatientNumber»

OPTIMAL INSTRUMENT

Difficulty–Baseline

Instructions: Please circle the level of difficulty you have for each activity today.	**Able to do without any difficulty**	**Able to do with little difficulty**	**Able to do with moderate difficulty**	**Able to do with much difficulty**	**Unable to do**	**Not applicable**
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about *all* of the activities you would like to do, please mark an "X" at the point on the line that best describes your *overall* level of difficulty with these activities today.



I have *extreme difficulty* doing any of the activities that I would like to do.

I have *no difficulty* doing any of the activities that I would like to do.

23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: *1. 12 2. 8 3. 13*)

1.____ 2.____ 3.____

Adapted/revised in July 2005 and August 2006 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). *Phys Ther.* 2005;85:515-530.