New Hanover Regional Medical Center

Name: _____ (Last Name) _____ (First Name) _____ (Middle Initial)

DOB: _____ MR#: _____

Acct#: _____

PATIENT INFORMATION FOR OUTPATIENT REHABILITATION

What are your goals for Therapy?

Please check current status: ☐Retired ☐Disabled ☐Homemaker ☐Student ☐ Other: _____

Work status: ☐ Full-time ☐ Part-Time ☐ Light Duty Employer: _____

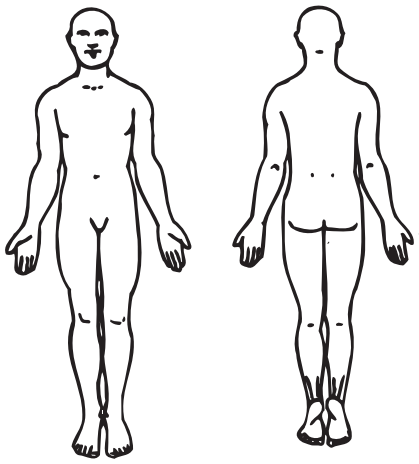
Please check any of the following conditions you have or have had:

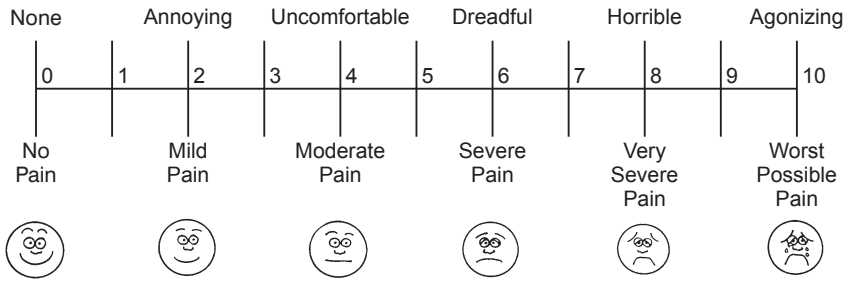
☐ Arthritis	☐ Fibromyalgia	☐ Osteoporosis	☐ Respiratory problems
☐ Cancer	☐ Fractures	☐ Pregnant (currently)	☐ Stroke
☐ Diabetes	☐ Heart disease	☐ Pacemaker/defibrillator	☐ Other: _____
☐ Digestive problems	☐ High blood pressure	☐ Injuries: _____	
☐ Dizzy spells	☐ History of falls	☐ Surgeries: _____	

☐ Check here if LATEX allergy Please list any other allergies: _____

Please list current medications (include Herbal and Over the Counter): ☐ Provided copy

Do you have pain? ☐ Yes ☐ No If yes, please rate your pain right now using the 0-10 scale below: _____ Rate at best: _____ At worst: _____	Is the pain: ☐ Continuous? ☐ Off and on? ☐ Other: _____	Do you have numbness, tingling or burning? ☐ Yes ☐ No





When is your next appointment with your referring doctor?

Do you have any cultural/religious issues or values/beliefs that would affect your care? ☐ Yes ☐ No
If yes, please describe.

Are you in a relationship with a person who threatens you or hurts you verbally, emotionally, physically, or sexually?
☐ Yes ☐ No

Is there anything else that you feel would be helpful for your therapist to know?

_____ _____ _____ _____

Patient or Patient Representative Signature Date Time Relationship

_____

Printed Name

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD

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