

REASON FOR REFERRAL: _____

AMBULATORY SUMMARY

HEALTH HISTORY (Check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> Difficulty Walking |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Recent Falls |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Dizziness or Blackouts |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Repeated Infections |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Infectious Disease (HIV, TB, Hepatitis, CDiff, MRSA, Shingles, Mono) |
| <input type="checkbox"/> Circulation/Vascular Problems | <input type="checkbox"/> Developmental Problems | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Broken Bones/Fractures | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes/High Blood Sugar | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Low Blood Sugar/Hypoglycemia | <input type="checkbox"/> Low Bone Density | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Cancer – where: _____ |
| <input type="checkbox"/> Peripheral Neuropathy | <input type="checkbox"/> Back/Neck Pain | <input type="checkbox"/> Sentinel Node Biopsy |
| <input type="checkbox"/> Ulcers/Stomach Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Lymph Node Removal |
| <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

SURGERIES / RECENT HOSPITALIZATIONS	DATE

MEDICATIONS / DOSE (include over the counter)	REASON FOR TAKING	DATE STARTED	D/C

Drug Allergies? No Yes, what and reaction: _____

Latex Allergies? No Yes, reaction: _____

Other Allergies/Reactions? . . . No Yes, specify: _____

Job/Employment _____ Student Retired

Indicate any Job restrictions due to the reason for referral: _____

Hobbies/Sports: _____

Do you currently participate in a regular exercise program? Yes No

Please describe: _____

YOUR GOAL FOR THERAPY: _____

PAIN ASSESSMENT:

Do you have pain now? Yes No

Have you had pain in the recent past? Yes No

If you answered yes to one of the above questions, please complete the following:

Where is your pain located? _____

What makes your pain feel better? _____

What makes your pain feel worse? _____

On a scale of 0-10, with 0 being no pain and 10 being the greatest amount of pain possible, how intense is the pain now? _____

What is your pain goal on the 0-10 scale? _____

SOCIAL HISTORY:

Who will be helping you at home? _____

Living arrangements: Apt/Condo House Facility

Any stairs in your home? No Yes, number: _____

Railing on the: Right Left None

Do you feel safe at home? Yes No

Do you have feelings of hopelessness or thoughts of harming yourself? Yes No

Do you smoke? Yes No

Do you have concerns about your nutrition? Yes No

EDUCATION PLAN:

How do you prefer to learn new things? written verbal video handout demonstration

Primary language spoken: English Spanish Other: _____

Do you require a translator? Yes No

Do you have any of the following barriers to learning? changes in memory learning impairment unable to read hard of hearing vision changes

Do you have any cultural or religious practices that the therapist should be aware of? Yes No

If yes, please describe? _____

STOP! THERAPY STAFF WILL COMPLETE THIS SECTION:

PRIMARY DIAGNOSIS: PT _____ OT _____ ST _____

OTHER REHAB NEEDS IDENTIFIED NOT ALREADY ADDRESSED? NO YES, MD NOTIFIED: _____

FALL PRECAUTIONS NO YES

ANTICOAGULATION PRECAUTIONS NO YES

SUICIDE RISK NO YES, MD NOTIFIED: _____

ABUSE/NEGLECT CONCERNS NO YES, MD NOTIFIED: _____

NUTRITIONAL NEEDS IDENTIFIED? NO YES, MD NOTIFIED: _____

DISCHARGE PLANNING/EDUCATIONAL NEEDS: HOME EXERCISE PROGRAM/WELLNESS PROGRAM

DISEASE INFORMATION SELF CARE

PAIN MANAGEMENT OTHER: _____

I HAVE REVIEWED THIS FORM AND WILL UPDATE THE INFORMATION AS CHANGES OCCUR.

THERAPIST SIGNATURE: _____ DATE/TIME: _____ LICENSE # _____

**LEE MEMORIAL HEALTH SYSTEM
Lee County, Florida**

REHABILITATION SERVICES

HEALTH HISTORY CARE LOG

FM# 5394 07/09 Page 2 of 2

UCO TAB - HISTORY & PHYSICAL