CAPITAL HEALTH

Rehabilitation Services Department

SUMMARY LIST

(page 1 of 2)

Patient name:_____
Date of birth:_____
Account

Past Medical History Check all that apply		Yes	No	Therapist Comments
Heart Disease	*	☐	☐	
High Blood Pressure	*	☐	☐	
Heart Attack	*	☐	☐	
High Cholesterol	*	☐	☐	
Heart Failure	*	☐	☐	
Circulation problems		☐	☐	
Asthma / Lung Problems	*	☐	☐	
Diabetes		☐	☐	
Changes in sensation		☐	☐	
Amputations		☐	☐	
Kidney Problems	*	☐	☐	
Dialysis		☐	☐	
Stroke / TIA	*f	☐	☐	
Liver Disease	*	☐	☐	
Are you taking more than 4 prescription medications?	f	☐	☐	

Past Medical History Check all that apply		Yes	No	Therapist Comments
Cancer		☐	☐	
Chemotherapy		☐	☐	
Radiation		☐	☐	
Parkinson's Disease	f	☐	☐	
Arthritis: Rheumatoid		☐	☐	
Osteoarthritis		☐	☐	
Osteopenia/Osteoporosis		☐	☐	
Fractures		☐	☐	
Thyroid Disease		☐	☐	
Seizures		☐	☐	
Balance Problems	f	☐	☐	
Previous Injuries		☐	☐	
Other:		☐	☐	
Have you had a fall in the past 6 months?	f	☐	☐	
Trouble getting up from a sitting position?	f	☐	☐	

Current Health - check any symptoms you are currently experiencing		Yes	No	Therapist Comments
Chest pain	*	☐	☐	
Shortness of breath		☐	☐	
Nausea / vomiting	*	☐	☐	
Fever / chills / sweats		☐	☐	
Bowel / urinary changes		☐	☐	
Night pain		☐	☐	
Numbness / weakness		☐	☐	
Recent weight change		☐	☐	
Fainting / dizzy	f	☐	☐	
Tired / sleep difficulty		☐	☐	
Skin problems		☐	☐	
Visual problems		☐	☐	
Hearing problems		☐	☐	
Other:		☐	☐	

Social History		Yes	No	Therapist Comments
Do you exercise?		☐	* ☐	
Do you smoke?	*	☐	☐	
Do you drink alcohol?		☐	☐	
Do you use drugs?		☐	☐	
Do you have anxiety?		☐	☐	
Do you get depressed?		☐	☐	
Do you want information on Advance Directives?		☐	☐	
What is your height?		_____		
What is your weight?*		_____		
Do you have a need to discuss any emotional or physical harm that you may be experiencing?		☐	☐	

For Medications & Allergies See Med Rec Form

Fall Risk: Any "yes" response to items with "f" designates a potential fall risk: YES NO

Pt was educated about fall prevention: YES NO Written information on fall prevention was provided: YES NO

Cardiovascular Risk Rating (definition): LOW =1* MOD=2or more* &no CV symptoms HIGH= 2 or more* & CV symptoms

Patient signature:_____ Date:_____ Time:_____

Therapist signature (lic#):_____ Date:_____ Time:_____

SUMMARY LIST
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Patient name:_____
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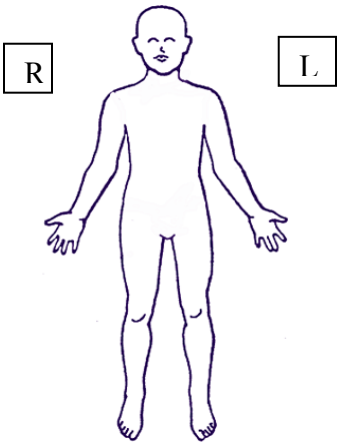
Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.



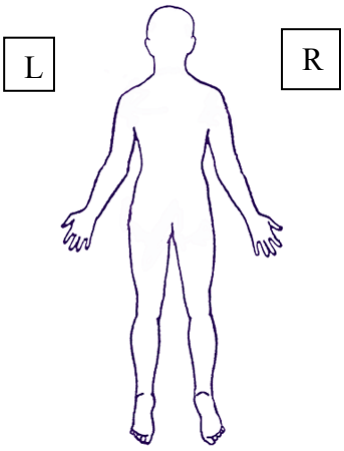
Numbness
IIIIII

Pins and Needles
00000

Burning
xxxxx

Stabbing
//////

Ache
⊥⊥⊥⊥⊥



Pain Rating Scales
0-10 visual analog scale

0 1 2 3 4 5 6 7 8 9 10

no pain — **worst possible pain**

Date of procedure	Please list your surgical/procedural history	Date of procedure	Surgical /procedural (continued)

Date	Please list any medications you currently take	Date	Please list any allergies that you have

Medications:

☐ I have brought in a list of all my current medications.

☐ I will bring a complete list of my medications at my next visit.

Patient Signature: _____ Date: _____ Time:_____

Therapist Signature (lic#): _____ Date:_____ Time:_____