McLaren MACOMB

Date of Birth:

REHABILITATION SERVICES - PATIENT MEDICAL HISTORY FORM

**** Please complete as thoroughly as possible. This information will remain confidential.***

Why are you here/Current Condition? _____

Currently Working: ☐ Yes ☐ No Occupation: _____

Circle activities you do at work: Sit Stand Walk Lift (____ pounds) Carry (____ pounds)

Dominant Hand: Right ☐ Left ☐ **Involved Side, if applicable:** Right ☐ Left ☐ ***Height*** ____ ***Weight***____

Did you have Physical / Occupational / or Speech Therapy while an in-patient at McLaren Macomb Hospital in the last two to three months? - please check: **Yes** ☐ **No** ☐

Did you have McLaren Home Care? - please check: **Yes** ☐ **No** ☐

How did you hear about us: **Hospital Staff** ☐ **Home Care** ☐ **Physician** ☐

Former Patient ☐ **Family/Friend** ☐ **Other** _____

Please indicate any previous treatments that have been tried for your CURRENT condition:

Treatment	Yes	No
Nerve Blocks		
Injections		
Ice/Heat		
TENS Unit		

Treatment	Yes	No
Orthotic / Splint		
Manipulations		
Vocal Rest		
Acid Reflex Meds.		

Treatment	Yes	No
Chiropractic/OMM		
PT / OT / Speech		
Massage		
Other _____		

Circle any Diagnostic Testing you have had done related to your CURRENT condition:

X-ray EMG Bone Scan MRI CT Scan/PET Scan Blood Work Laryngoscopy/Endoscopy

Do you CURRENTLY receive Home Health Care (PT, OT, Speech, Nursing, Aide)? ☐ Yes ☐ No

Preferred Learning Method (please circle): pictures reading listening participatory other _____

Health History: (Check "yes" or "no")	Yes	No		Yes	No		Yes	No
High Blood Pressure			Visual Difficulties			Swallowing Difficulties		
High Cholesterol			contacts/glasses			Fainting Spells		
Heart Attack			Dentures			Hepatitis / HIV		
Pacemaker			Recent Weight Loss/Gain			Stroke		
Irregular Heartbeat			Memory Problems			Blood Clots		
Congestive Heart Failure			Hearing Problems			Rheumatoid Arthritis		
Asthma			Thyroid Disorders			Osteoarthritis		
Emphysema/Chronic Bronchitis			Seizures / Convulsions			Osteoporosis		
Difficulty Breathing			Headaches			Are you Pregnant?		
Cancer: Type-			Fever, Sweats, Chills			Nausea / Vomiting		
Surgically Implanted Stimulator			Fracture/Sprain/Strains			Recent Infection		
General Weakness/Fatigue			Where?			Stomach Disorders		
Dizziness, Light Headedness			Psychiatric Problems			Bleeding Disorders		
Bowel/Bladder Problems			Depression/Anxiety			Diabetes		
(urgency, frequency, blood)			Acid Reflex/GERD/Heartburn			Skin Disorder		
Other:								

CIRCLE any equipment you have at home that you routinely use:

Cane Walker Wheelchair TENS Unit Tub/Shower Seat Bathing/Dressing Aides

Other _____

Please answer the following questions regarding your current living situation:

1. I live in a _____ story home. Bedroom and bathroom are on ☐ main floor ☐ 2nd floor
2. I have _____ steps to get into the home. ☐ with railing ☐ without railing
3. I have a basement ☐ yes ☐ no ☐ with railing ☐ without railing
4. I live ☐ alone ☐ with spouse ☐ with parent ☐ with child ☐ other _____

CIRCLE your main responsibilities at home prior to your injury or illness:

Cooking Cleaning Laundry Yard Maintenance Home Maintenance Other _____

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Do you smoke: ☐ Yes ☐ No How Much? _____

Do you consume alcoholic beverages: ☐ Yes ☐ No How Much? _____

List Medications: (include prescription-including dosages, non-prescription and herbal supplements)

Current Medication List: ☐ See attached list

Medication	Dosage	Medication	Dosage

List any known allergies: (latex, tape, lotion, medications, bee sting, etc.: ☐ No known allergies

List of Prior Surgeries (Start with most recent): ☐ See attached list

Surgery	Date	Surgery	Date

Have you fallen within the past year?: ☐ Yes ☐ No

Did any fall result in injury: ☐ Yes ☐ No Type of Injury: _____

Do you feel unsafe with your partner or anyone else? ☐ Yes ☐ No

Have you ever been verbally, emotionally, physically, or sexually harmed / threatened / financially exploited by your partner or anyone else? ☐ Yes ☐ No

Office Use Only:	**Additional Therapist Comments:**
Intervention/follow-up: ☐ None needed ☐ Educational packet issued ☐ Fall Risk ☐ Abuse/Neglect resources ☐ Other:	

By signing, I certify that this assessment form is accurate to the best of my knowledge.

Patient Signature _____ Date: _____

Patient self-assessment reviewed:

Therapist: _____ Date: _____ Time: _____