★★★ **Are you currently receiving ANY home health services?** ❑ **YES** ❑ **NO**

Name: ______________________________ Age:_____ Today's Date: ______________

Describe the problem that brings you to therapy:______________________________

____

____

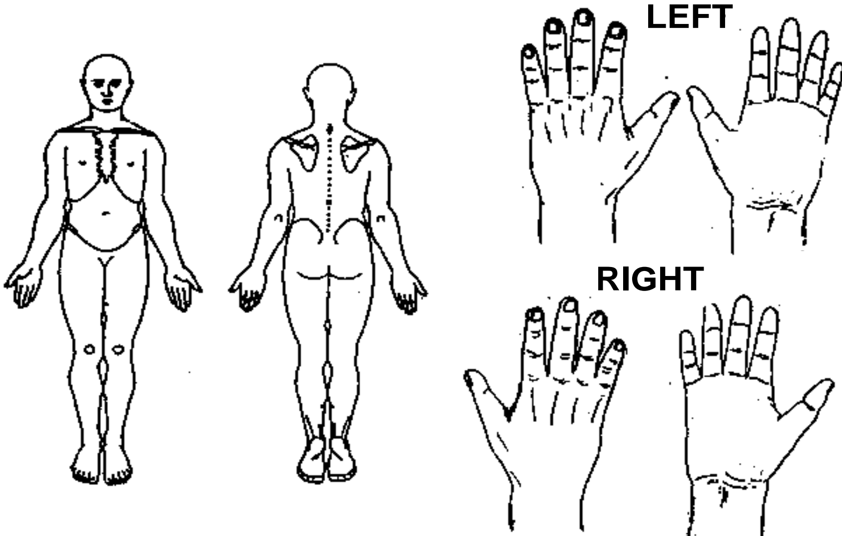
Date problem began:______________________________

What is your goal as a result of this treatment?______________________________

Do you have pain? ❑ YES ❑ NO → If yes, please rate your pain on the following pain scale: (Circle the number.)

0 (none)	1	2	3	4	5	6	7	8	9	10 (Severe)

If you do have pain, please indicate on the drawings below where your pain is.



Have you had any outpatient physical therapy, occupational therapy, and/or speech-language pathology for any reason since January 1 of this year?
❑ YES ❑ NO
If yes, please describe:

____

____

____

____

____

Describe what you do to keep physically fit:______________________________

Languages you speak: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other: ______________
Preferred language for discussing healthcare: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other: ____________
Preferred method of communication: ❑ Verbal ❑ Sign Language ❑ Written ❑ Video ❑ Other: ______________

Are you pregnant now or is there a chance you could be? ❑ YES ❑ NO
Have you taken steroids for a prolonged period of time? ❑ YES ❑ NO

Have you had any tests in the past 6 to 12 months? (X-Ray, CT Scan, MRI, EMG, ECG, etc) ______________

____

In the space below, please tell us anything else you think your therapist will need to know: ______________

____

____

→→→ OVER →→→

09.0001

Olathe Medical Center
20333 West 151st Street
Olathe, Kansas 66061

OUTPATIENT PHYSICAL & OCCUPATIONAL THERAPY INTAKE QUESTIONNAIRE & OUTPATIENT SUMMARY

9.25.2017; Rehab **O.M.C. No. 1082**

PLACE
PATIENT LABEL
HERE

Past Medical History: Do you have ANY previous history of the things listed below?

CONDITIONS:	YES	NO	CONDITIONS:	YES	NO
High Blood Pressure			Pacemaker		
Heart Condition			Seizures		
Stroke(s)			Cancer		
Metal Implants			Shortness of Breath		
Diabetes			Asthma		
Memory Difficulties			Persistent Night Pain		
Dizziness or Light Headedness			Frequent/Severe Headaches		
Excessive Fatigue			**Unexplained** Weight Loss		
Broken Bones (fractures)			Past or Current Bowel/Bladder dysfunction		
Fibromyalgia			Gynecological Issues		
Arthritis			Vaginal/Cesarean Birth (Number: _______)		
Thyroid Problems			→ Did you have any back pain with your		
Kidney Problems			pregnancy or after childbirth?		
Blood Clots and/or Poor Circulation			Other:		

Staff Initials	Date	Time	**ALLERGIES** **Do you have any allergies?** ☐ **No** ☐ **Yes, please list:**	**REACTION(S)**

Staff Initials	Date	Time	**OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS** **Do you have any other diagnoses &/or significant conditions?** ☐ **No** ☐ **Yes, please list:**

Staff Initials	Date	Time	**PREVIOUS PROCEDURES / SURGERIES** **Do you have any previous procedures or surgeries?** ☐ **No** ☐ **Yes, please list:**

Staff Initials	Date	Time	**CURRENT MEDICATIONS** ☐ **See attached list of medications that the patient provided.** **Are you currently taking any medications, including herbals?** ☐ **No** ☐ **Yes, please list:**

TIME/DATE	INITIALS	STAFF SIGNATURE	TIME/DATE	INITIALS	STAFF SIGNATURE

TIME: ___________ DATE: __________ PATIENT SIGNATURE: ____