BRONSON Bar Code Here

Name: _____
Birthdate: _____

Please complete this form before you see the therapist. This information will help the therapy team to better understand your current condition and how we can work together to best meet your needs.

The following individuals have my consent to pick up or accept phone calls regarding my schedule: □None

Please list: _____

What are the problems that bring you to therapy? _____

What are your goals for therapy? _____

Have you ever had treatment for these problems in the past? □ No □ Yes □ I don't know

If yes, what kind? □ Surgery□ Physical Therapy □ Occupational Therapy □ Acupuncture □ Massage
□Other_____

Where do you live? □ Home □ Apartment □ Group Home □ Assisted Living □Other _____

Do you live alone? □ No □ Yes

Do you have to use stairs? □ No □ Yes How many? _____

Daily activity level:

□ Low (Example, I need help to do household chores, dress and bathe myself)

□ Medium (Example, I need some help, but can do about half on my own)

□ High (Example, I can do all household chores and self care on my own, but have symptoms)

What daily activities are difficult now due to your current problems? _____

_____

What kind of hobbies are you having a hard time doing? _____

_____

Do you have access to gym equipment? □No □Yes What type? _____

Do you currently work? □No □Yes

If yes, what is your current work activity:

□ Regular Duty. I work _____ hours a day _____ days a week.

□ Limited or light duty. Date light duty began: _____

□ Off work currently. Date taken off work: _____

Can you return to work with restrictions? □No □Yes

If you are lifting at work, what is the average weight you lift? _____ Maximum weight _____

How many times per hour? _____

Height _____ Weight _____ What is your dominant hand? □Right □Left □Both

At the present time would you say your health is: □Excellent □Very Good □Good □Fair □Poor

BRONSON Bar Code Here

Name: _____
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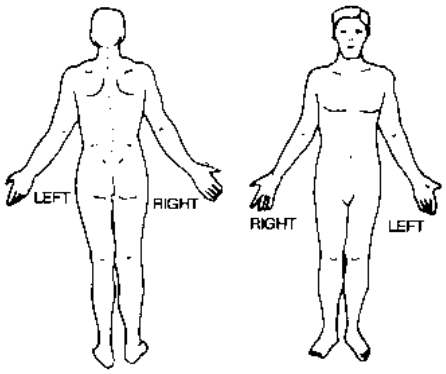
Please mark the area(s) where you are experiencing the problems that brought you here.

Back **Front**



Since these problems began, have you experienced any of the following?

□ Change in appetite	□ Changes in bowel or bladder patterns	□ Changes in your mood
□ Change in vision	□ Change in swallowing	□ Pregnancy
□ Dizziness/Fainting	□ Falls/balance	□ Fever
□ Headache	□ Memory problems	□ Night sweats
□ Numbness	□ Pain	□ Ringing in ears
□ Shortness of breath	□ Tingling	□ Unexplained weight loss/gain

Do you have any other conditions that may affect your healing and therapy? □ No □Yes
Please describe: _____

Medical

Please check all that apply:

□ I use tobacco: □ Cigarettes (_____ per day) □ Chew □ Pipe

□ I drink alcohol. Number of drinks a day _____.

□ I drink or eat caffeine. Number of servings a day _____

Do you feel safe at home? □ No □ Yes

Do you feel adequately cared for? □ No □ Yes

Patient Signature: _____ Date: _____

Reviewed by: □ OT Signature _____ Date: _____

□ PT Signature _____ Date: _____

□ SLP Signature _____ Date: _____

BRONSON Bar Code Here

Name: _____
Birthdate: _____

What tests have been done?

□ X-rays □ MRI □ CT Scan □ Bone Scan □ PET □ Other _____

□ Check here if any of these were completed at Bronson

Do you have any tests scheduled? □No □Yes What and when? _____

Please list all medicines you are taking (unless you brought a current list with you): _____

_____

_____

_____

List any supplements, herbs, or changes to diet: _____

_____

Please check all of the following conditions you have had:

□ Allergies
□ Arthritis – type _____
□ Birth defects
□ Blood clots/circulation problems
□ Cancer – type/area _____
□ Chronic anemia
□ Depression
□ Diabetes
□ Diverticulitis
□ Eating disorders
□ Fibromyalgia
□ GERD/Reflux
□ Glaucoma
□ Heart disease/chest pain/palpitations
□ Hepatitis – A, B, C
□ Hernia
□ Hiatal hernia
□ High blood pressure
□ Joint replacement
□ Kidney/bladder problems
□ Liver/Gallbladder problems
□ Lung disease/Asthma/breathing difficulties
□ Metal implants
□ Osteoporosis/Osteopenia
□ Pacemaker
□ Poor tolerance to cold
□ Previous head injury
□ Seizures
□ Skin abnormalities
□ Spinal stenosis
□ Stroke
□ Thyroid disease
□ Tuberculosis/Persistent cough

Please list any surgeries, fractures, dislocations or hospitalizations:

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

In the past month, have you used home health services? □ No □ Yes

In the past month, have you seen any other health providers? □ No □ Yes

If yes, who? _____