AdventHealth Ottawa

PATIENT INTAKE FORM

Gollier Rehabilitation & Wellness Center

Name:_____ Day Time Phone:_____

Cell Phone:_____ Age:_____ Height:_____ Weight: _____

Medical Diagnosis: _____

Present complaint & cause of injury: _____

_____

Condition prior to incident/onset:_____

_____

Date of symptoms onset and/or date of surgery: _____

Has your problem changed since onset: _____

Have you received outpatient PT, OT, or Speech Therapy services this past year? ❑ Y ❑ N

If so, by whom and where? _____

Are you being seen in home health at this time? ❑ Y ❑ N _____

Current medications (Please submit list of meds if available):_____

List allergies: _____

Do you smoke cigarettes? ❑ Y ❑ N

HISTORY

Have you ever had any of the following?

❑ Anemia	❑ Headaches	❑Pacemaker
❑ Arthritis	❑ Heart Problems	❑Pregnant at this time
❑ Asthma/bronchitis/ emphysema	❑ Hepatitis	❑Seizures
	❑ Hemophilia	❑Shortness of breath
❑ Bowel/Bladder Changes	❑ Hernia	❑Stroke
❑ Cancer/Type:_____		
❑ Chemical Dependency	❑ High BP	❑Swollen ankles
❑ Chest pain	❑ HIV	❑ Urinary tract infection
❑ Depression	❑ Kidney problems	❑ Fainting
❑ Diabetics	❑ Metal Implants	❑ Dizziness

❑ Other (please list)_____

List any surgeries with dates: _____

_____

OBJECTIVES

Primary reason for attending therapy: (choose all that apply)

❑ Unable to work	❑ Activity Reduction	❑ Limited motion
❑ Surgery	❑ Loss of independence	❑ Pain
❑ Unable to do household tasks	❑ Frequent Falls/decreased balance	
❑ Unable to play sports or recreational activities		

Please turn page over and complete the other side

What are your personal goals for therapy: (choose 4 that are most important)

❑ Decrease pain ❑ Increase strength ❑ Improve sleep
❑ Increase sitting tolerance ❑ Improve posture ❑ Gain/lose weight
❑ Increase standing tolerance ❑ Increase mobility ❑ Return to work activities
❑ Resume/Improve Fitness ❑Increase walking distance and speed

Pain ranking (0-10) at its worst? _____ at its best?_____
Is the pain better any time of day?_____
Is the pain worse any particular time to the day?_____
What in particular makes your pain worse? _____
What, if anything, eases your pain?_____
What else have you tried to improve your function/decrease your pain?_____
_____
Occupation: _____
Current work status ❑ Full duty ❑ Light duty ❑ Not working
Living Arrangement: ❑ Alone ❑ Spouse/significant other ❑ Other family &/or friends
Routine activities you need to perform at work/home? _____
_____
Exercise Program (list activities you do to maintain/improve your fitness level):
_____

For speech and/or language problems, please answer the following:

Describe your speech and/or language problem:_____
What is your primary language and method of communication:_____
Are there any other speech-language, learning, or hearing problems in your family? ❑ Y ❑ N
If yes, describe:_____
Do you have any eating/swallowing difficulties? ❑ Y ❑ N If yes, describe: _____

Please provide any information that may be helpful in the evaluation process:

Because we believe our patients must take an active role in their rehabilitation, it is the policy of AdventHealth Ottawa Rehabilitation Services that when a patient misses three (3) consecutive sessions for any reason, or after the second (2) no show, the patient is discharged from Rehabilitation Services. If this occurs, the patient must see their physician to get a new prescription to resume therapy.

The AdventHealth Ottawa Rehabilitation Services Department requests that it be notified at least 24 hours in advance of any patient cancellation. This allows us sufficient time to notify other patients of the open appointment time. Any cancellation of a scheduled appointment less than 24 hours or missed appointment without notification of the clinic will be charge of $25.

I hereby certify that I have read and accurately completed the above intake form to the best of my knowledge.

Patient Signature: _____ Date:_____