OUTPATIENT DEPARTMENT
INTAKE INFORMATION

Name: ___________________________________________ Today’s Date: ____________________________

Diagnosis: __________________________________________

Chief complaint: __________________________________

Patient Phone Number: ___________________________ Patient Email: ____________________________

Emergency Contact: ______________________________ Phone No. ____________________________

Preferred Language: ___________ Do you have an Advanced Directive? Y / N / Packet Given

Have you been diagnosed with or ever experienced the following? Please circle a response to each:

- High Blood Pressure Y / N
- Seizures Y / N
- Asthma Y / N
- Cancer Y / N
- Depression or mood disorder Y / N

- Heart Disease Y / N
- Diabetes Y / N
- Stroke Y / N
- Kidney Disease Y / N
- Osteoporosis Y / N

Over the Past 2 weeks, how often have you been bothered by the following problems? (circle the appropriate choice)

1. Little interest or pleasure in doing things
   - Not at all
   - Several days
   - >half the days
   - Nearly every day
   0 1 2 3

2. Feeling down, depressed or hopeless
   - Not at all
   - Several days
   - >half the days
   - Nearly every day
   0 1 2 3

Surgeries: __________________________________________

Referring Clinician: ___________________________ Phone Number: ____________ Fax Number: ____________

Other Provider: ___________________________ Phone Number: ____________ Fax Number: ____________

Are you currently receiving any of the following services? Please circle:

- No other services
- Psychology/Neuropsychology
- Occupational Therapy
- Speech Therapy
- Physical Therapy at home / other facility
- Other Services: ___________________________

Medical Care or therapy received prior to this visit: __________________________________________

Revised 5/2017, 9/2019
Current Medication Being Taken: Will bring list

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<th>Name</th>
<th>Dosage/Day</th>
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Allergies: ________________________________

Rehab Precautions/Restrictions/Weight Bearing Status:

______________________________________________________________________________

What Activities are difficult for you due to your current condition?

______________________________________________________________________________

What are your specific goals for your therapy?

______________________________________________________________________________

Describe Current Living Situation:

______________________________________________________________________________

Do you feel safe in your home? Y / N. If no, explain:

______________________________________________________________________________

Marital Status: ____________________Children? Y / N

Employment Status: ____________________Recreational Activities:

Type of transportation you will be using to come for therapy:

Do you have a condition which you feel has affected your balance? Y / N Recent Falls? Y / N

Explain:

______________________________________________________________________________

Patient Signature

______________________________________________________________________________