OUTPATIENT DEPARTMENT

INTAKE INFORMATION

Name:_____**Today's Date**_____

Diagnosis_____**DOB**_____

Chief complaints:_____

_____

What are your specific goals for therapy? _____

_____

Date of Procedure or injury:_____ **Is this your 1st experience at Burke Outpatient**? Y / N

Referring Physician:_____**Telephone #**:_____

Fax #: _____

Primary Physician:_____**Telephone #**:_____

Fax #: _____

Other Physician:_____ **Telephone #**:_____

Fax #: _____

In Case of Emergency, Please Notify:_____

Telephone #:_____**Cell #**_____

BEST PHONE NUMBER (eg. cell phone) WHERE YOU CAN BE REACHED:_____

Email address (optional)_____

Primary Language_____

Type of transportation you will be using to come for therapy

_____

Are you currently receiving any home health services? Y / N **Explain**:_____

Please fill out the other side of this form

How would you describe your general health? Excellent____Good_____Fair_____Poor_____

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

High Blood Pressure	Y / N	Heart Disease	Y / N
Seizures	Y / N	Diabetes	Y / N
Asthma	Y / N	Stroke	Y / N
Cancer	Y / N	Kidney Disease	Y / N
Depression or mood disorder	Y / N	Other	Y / N

Please explain any of the above that you answered with a Yes

_____

Do you have a pacemaker or any implanted device? Y / N

Past Surgical History: _____

Current Medications being taken: **Name** **Dosage/day**

Will bring list of meds ☐

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

Explain:_____

Allergies_____ **Latex allergy**? Y / N

Prior Therapy history:_____

Occupation_____**Currently at work**? Y / N / Retired

Describe current living situation_____

Do you feel safe in your home? Y / N **If no, explain**_____

How did you hear about us?

- ☐ **Movie Theater Ads**
- ☐ **Print Ads**
- ☐ **Radio Commercials**
- ☐ **Cable/Public TV Commercials**
- ☐ **Word of mouth**
- ☐ **Former Patient**
- ☐ **Train station billboards**
- ☐ **Hospital For Special Surgery Network Referral**

Patient Signature_____

Please fill out the other side of this form