★★★ **Are you currently receiving <u>ANY</u> home health services? ❑ YES ❑ NO**

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

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: _____

Date of initial Neurological Diagnosis: _____

Initial Symptoms: _____

Current Symptoms:_____

Primary Care Doctor: _____ Neurologist: _____

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 write where your pain is located: _____

_____

Describe what you do to keep physically fit:_____

Social Information:

Do you live alone? ____ Does your home have stairs? _____ If yes, how many stairs? _____ Is there a railing?_____

Are you employed? ____ If yes, what job duties do you have? _____

If you are no longer employed, what type of work did you do in the past? _____

What household chores do you participate in? _____

Do you drive? _____

Do you use any type of assistive device such as a walker or cane? _____

Do you have any previous history of the following conditions?

Are you currently receiving any home health services? ❑ 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) _____

<u>Have you recently noted (**within the past 3 months**):</u>

Weight loss/gain	❑ YES ❑ NO	Weakness	❑ YES ❑ NO
Nausea/Vomiting	❑ YES ❑ NO	Fever/chills/sweats	❑ YES ❑ NO
Dizziness/lightheadedness	❑ YES ❑ NO	Numbness or tingling	❑ YES ❑ NO
Fatigue	❑ YES ❑ NO		

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: _____

➔➔➔ OVER ➔➔➔

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

_____

_____

For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

0% 10 20 30 40 50 60 70 80 90 100 %

How confident are you that you will not lose your balance or become unsteady when you…..

1. Walk around the house? ____%
2. Walk up or down stairs? ____%
3. Bend over and pick up a slipper from the front of a closet floor ____%
4. Reach for a small can off a shelf at eye level? ____%
5. Stand on your tiptoes and reach for something above your head? ____%
6. Stand on a chair and reach for something? ____%
7. Sweep the floor? ____%
8. Walk outside the house to a car parked in the driveway? ____%
9. Get into or out of a care? ____%
10. Walk across a parking lot to the mall? ____%
11. Walk up or down a ramp? ____%
12. Walk in a crowded mall where people rapidly walk past you? ____%
13. Are bumped into by people as you walk through the mall? ____%
14. Step onto or off an escalator while you are holding onto a railing? ____%
15. Step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? ____%
16. Walk outside on icy sidewalks? ____%

➔➔➔ OVER ➔➔➔

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		
Dizziness			Persistent Night Pain		
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 pregnancy or after childbirth?		
Kidney Problems					
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:

INITIALS	STAFF SIGNATURE	INITIALS	STAFF SIGNATURE

TIME: _____ DATE: _____ PATIENT SIGNATURE: _____

PLACE PATIENT LABEL HERE