$\star \star \star$ Are you currently receiving <u>ANY</u> home health services? \Box YES \Box NO

Name:	Age:	Today's Date:
January 1 of this year? YES	NO	eech-language pathology for any reason since
Date of initial Neurological Diagnosis:		
Initial Symptoms:		
Current Symptoms:		
Primary Care Doctor:	Neurologist: _	
	If yes, please rate your pain on the fo	llowing pain scale: (Circle the number.)
0 1 2 3 (none) 1 2	4 5 6	7 8 9 ¹⁰ (Severe)
	our pain is located:	
Describe what you do to keep physically	fit:	
Social Information:		
Do you live alone? Does your hom	ne have stairs? If yes, how m	nany stairs? Is there a railing?
Are you employed? If yes, what job	b 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 participat	e in?	
Do you drive?		
Do you use any type of assistive device s	such as a walker or cane?	
Do you have any previous history of the	ne following conditions?	
Are you currently receiving any home heat	alth services?	
Have you taken steroids for a prolonged p	period of time?	
Have you had any tests in the past 6 to 1	2 months? (X-Ray, CT Scan, MRI, EM	IG, ECG, etc)
Have you recently noted (within the pas	<u>t 3 months):</u>	
Weight loss/gain	□ NO Weakness □	YES 🗆 NO
Nausea/Vomiting	□ NO Fever/chills/sweats □ Y	YES 🗆 NO
Dizziness/lightheadedness	□ NO Numbness or tingling □ N	YES 🗆 NO
Fatigue D YES	□ NO	
Preferred language for discussing healthout	care: 🛛 English 🗳 American Sign La	□ Other: Inguage □ Spanish □ Other: □ Video □ Other:
	→→→ OVER →→→	
09.0205	PT / OT NEURO REHABILI	
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	OUTPATIENT SUMMA Page 1 of 3	RY PATIENT LABEL
Olathe Medical Center 20333 West 151 st Street		HERE
Olathe, Kansas 66061	9.25.2017; Rehab O.M.C. N	10. 2229

In the s	pace below, please tell us anything else you think your therapist will need to know:
	ch of the following activities, please indicate your level of self-confidence by choosing a corresponding or from the following rating scale: 0% 10 20 30 40 50 60 70 80 90 100 %
How c	onfident 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?%
	$\rightarrow \rightarrow $

09.0205

Olathe Medical Center

20333 West 151st Street

Olathe, Kansas 66061



PT / OT NEURO REHABILITATION INTAKE QUESTIONNAIRE & OUTPATIENT SUMMARY Page 2 of 3

PLACE PATIENT LABEL HERE

9.25.2017; Rehab

O.M.C. No. 2229

Past Medical History	/: Do	you have ANY	previous histor	y of the things	listed below?
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High Blood Pressure Pacemaker Heart Condition Seizures Heart Condition Seizures Metal Implants Cancer Diabetes Asthma Dizzness Persistent Night Pain Light Headedness Past or Current Bowe/Bladder dysfunction Fibromyalgia Gynecological Issues Athritis Vaginal/Cesarean Bifth (Number: _) Thyroid Problems Did you have any allergies? No Yes, please list: Blood Clots and/or Poor Circulation Other: Staff Date Time OrtHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS Initials Date Staff Date Time Other Do you have any previous procedures or surgeries? No Yes, please list:				YES	NO	CONDITIONS:		YES	NO
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TIME: _____

DATE: ____

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PT / OT NEURO REHABILITATION INTAKE QUESTIONNAIRE & OUTPATIENT SUMMARY Page 3 of 3

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