PREHAB INTAKE SUMMARY

Name:_____ Date of Birth:_____ Today's Date:_____

What joint are you having replaced? ❑ Hip ❑ Knee ❑ Left Side ❑ Right Side

Have you had a previous total joint replacement? ❑ No ❑ Yes → Which joint and when?_____

What is your goal after you receive a total joint replacement?_____

HOME ENVIRONMENT

Do you live: ❑ Alone ❑ With others

How many stairs do you have to get into your home from outside?_____ Is there a railing? ❑ Yes ❑ No

Do you have to climb stairs to get to: Bedroom? ❑ No ❑ Yes → How many? _____ Railing? ❑ Yes ❑ No

Bathroom? ❑ No ❑ Yes → How many? _____ Railing? ❑ Yes ❑ No

Laundry? ❑ No ❑ Yes → How many? _____ Railing? ❑ Yes ❑ No

In your bathroom, do you have: ❑ Tub ❑ Walk-In Shower

Is your bathroom equipped with any special equipment? ❑ None ❑ Grab bars in tub/shower
❑ Grab bars by toilet ❑ Bath/Shower seat or bench
❑ Raised toilet seat ❑ Other: _____

Do you have any of the following in your home? ❑ Throw rugs ❑ Pets ❑ Small Children

CURRENT FUNCTIONAL LEVEL

Have you had any falls in the last year? ❑ No ❑ Yes → Please explain: _____

Are you currently either working, volunteering, or providing caregiving duties? ❑ Yes ❑ No

If yes, please provide details:_____

Are you able to do the following?

Dressing activities:	❑ By myself ❑ With Assistance	Stair climbing:	❑ By myself ❑ With Assistance
Bathing:	❑ By myself ❑ With Assistance	Household chores:	❑ By myself ❑ With Assistance
Toilet hygiene:	❑ By myself ❑ With Assistance	Driving	❑ By myself ❑ With Assistance
Cooking:	❑ By myself ❑ With Assistance	Grocery shopping:	❑ By myself ❑ With Assistance

Who will be assisting you with daily activities (dressing, bathing, mobility, & driving) after surgery & for how long?

_____

MOBILITY/WALKING

Approximately how long or how far can you walk before needing to rest?_____

Do you use an assistive device to walk, such as a cane or walker? ❑No ❑Yes at home ❑Yes in the community

What device(s) do you use?_____

Do you use assistive devices for any other activities, such as a reacher, sock aid, etc.? ❑ No ❑ Yes

If yes, please describe? _____

Are you currently receiving any community support services, such as Meals on Wheels, etc.? ❑ No ❑ Yes

If yes, please describe? _____

Name three (3) barriers you perceive may limit your ability to return home after surgery.

1._____ 2. _____

3. _____

→→→→→→→ OVER →→→→→→→

OUTPATIENT REHABILITATION INTAKE SUMMARY

Languages you speak: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other _____

Preferred language for discussing healthcare: ❑ English ❑ American Sign Language ❑ Spanish ❑ Other _____

Preferred Mode of communication: ❑ Verbal ❑ Sign Language ❑ Written ❑ Other _____

Past Medical History: Do you have any previous history of the following conditions?

High Blood Pressure:	❑ Yes	❑ No	Severe Emotional Disturbance:	❑ Yes	❑ No
Heart Condition/Pacemaker:	❑ Yes	❑ No	Persistent Night Pain:	❑ Yes	❑ No
Strokes:	❑ Yes	❑ No	Cancer:	❑ Yes	❑ No
Diabetes:	❑ Yes	❑ No	Respiratory Disorders/Short of breath:	❑ Yes	❑ No
Broken Bones (Fractures):	❑ Yes	❑ No	Excessive Fatigue:	❑ Yes	❑ No
Metal Implants:	❑ Yes	❑ No	Frequent/Severe Headaches:	❑ Yes	❑ No
Arthritis:	❑ Yes	❑ No	Unexplained Weight Loss/Gain:	❑ Yes	❑ No
Fibromyalgia:	❑ Yes	❑ No	Change in Bowel/Bladder Function:	❑ Yes	❑ No
Seizures:	❑ Yes	❑ No	Any communicable disease:	❑ Yes	❑ No

ALLERGIES Do you have any allergies? ❑ No ❑ Yes, please list:	**REACTION**

OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS Do you have any other diagnoses or significant conditions? ❑ No ❑ Yes, please list:	**Staff Use Only**		
	Time	**Date**	**Signature**

PREVIOUS PROCEDURES / SURGERIES Did you have any other previous procedures / surgeries? ❑ No ❑ Yes, please list:	**Staff Use Only**		
	Time	**Date**	**Signature**

CURRENT MEDICATIONS, INCLUDING HERBALS Are you currently taking any medications, including herbals? ❑ No ❑ Yes, please list:	**Staff Use Only**		
	Time	**Date**	**Signature**
❑ See attached list			

Time _____ Date _____ Patient Signature _____

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