McLEAN REHABILITATION

Patient History

Patient Name: _____

Phone #: _____

Date of Birth: _____

Date: _____

1. Why are you coming to therapy at this time? _____

   _____

2. Do you have any physical limitations or restrictions? _____

   _____

3. Do you have difficulty or need help with activities of daily living, such as household chores, personal care, work or hobbies? If yes, briefly describe. _____

   _____

4. Are you working now? ❒Yes ❒ No If no or retired, how long have you been out of work? _____
5. What is/was your occupation? _____

   ❒ Full time ❒ Part time ❒ Light duty ❒ Retired
6. Do you have pain? ❒ Yes ❒ No If yes, please indicate where _____
7. Rate how confident you are in your driving skills.

   ☐ _____|_____|_____|_____|_____|_____|_____|_____ ☐

   Very confident Uncertain Insecure
8. In the last six months, have you gotten lost while driving on a familiar route? _____
9. What is your purpose for driving? _____
10. In the last six months, have you been limited in participating in activities outside of your home?

    ❒Yes ❒ No

    Please rate how limited you are in participating in activities outside of your home.

    ☐ _____|_____|_____|_____|_____|_____|_____|_____ ☐

    Not limited Homebound
11. Do you have a past or present history of any of the following?

❒ High blood pressure	❒ Hearing problems	❒ Fall with or without injury
❒ Heart disease	❒ Osteoporosis	❒ Bladder or bowel problems
❒ Heart attack	❒ Cancer	❒ Metal implants
❒ Have a pacemaker	❒ Respiratory problems	❒ Prosthetics/orthotics
❒ Stroke	❒ Asthma	❒ Depression
❒ Seizures/epilepsy	❒ Skin problems	❒ Motor vehicle accident(s)
❒ Circulation problems	❒ Dizziness/vertigo	❒ Severe sports injuries
❒ Diabetes	❒ Vision problems	❒ Fractures
❒ Arthritis	❒ Swallowing problems	❒ Alcohol use
❒ Neurological disease	❒ Headaches	❒ Smoking

12. Please list prior serious injuries, fractures, surgeries, and hospitalizations (including dates): _____

Name: _____ DOB: _____
Date: _____

_____

_____

_____

_____

_____

13. Please list any allergies you have: _____

_____

14. Please list medications you are taking, if any: _____

_____

_____

_____

_____

15. When is your next doctor appointment? _____ With who? _____

My signature confirms the above information.

Signature: _____ ***Date:*** _____