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

What are you being seen for today? _____

Do you have pain? _____ If yes, where do you have pain? _____

Have you received any Home Care services in the past 60 days? ☐ Yes ☐ No If yes, What agency _____

Have you been a resident in a Skilled Nursing Facility in the last 100 days: ☐ Yes ☐ No
If yes, what facility: _____

What are your goals and/or your caregivers goals for therapy? _____
_____

What is your preferred learning style for new information? ☐ Written ☐ Demonstration and practice ☐ Verbal instructions
☐ All ☐ Other: _____

Are there any special challenges/barriers to learning that you would like us to know about? _____

What would make your rehab/wound care experience excellent? _____

Do you fear for your personal safety at home? ☐ Yes ☐ No If yes, explain?_____

During the past month, have you been bothered by feeling depressed or hopeless? ☐ Yes ☐ No

During the past month, have you been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No
If yes, please comment: _____
_____

Do you have any thoughts of suicide? ☐ Yes ☐ No

		If yes, please describe how we can accomommodate your wishes
Do you have any specific cultural beliefs or alternative therapy practices that would impact delivery of your care?	☐ Yes ☐ No	
Would you like information about financial, community resources or adjustment concerns?	☐ Yes ☐ No	
Do you have trouble speaking and understanding English?	☐ Yes ☐ No	
Do you have trouble reading and writing English?	☐ Yes ☐ No	
Would you like an interpreter?	☐ Yes ☐ No	
Primary spoken language?	☐ Yes ☐ No	
Preferred language for healthcare information?	☐ Yes ☐ No	

List any medicines you now take or give copy to therapist: ☐ Medication list provided (see attached)
Managing your medication list is important. Give a list of your medications to your primary care physician, update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products are added,) and carry medication information with you at all times in the event of emergencies.

Medications - Dose / Frequency	Comments / Updates

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WakeMed Rehab
Outpatient Services
Intake Profile and Problem List

Allergies	Reaction	Onset
1.		
2.		
3.		
4.		

Any surgeries or injuries: If yes, please explain and date: _____

_____

_____

Medical History: Have you ever had or currently have:		Please Explain:
Asthma or other respiratory problems	☐ Yes ☐ No	
Shortness of breath	☐ Yes ☐ No	
Seizures/convulsions/epilepsy	☐ Yes ☐ No	
COPD (Chronic Obstructive Pulmonary Disease)	☐ Yes ☐ No	
Stroke	☐ Yes ☐ No	
TIA's (ministrokes)	☐ Yes ☐ No	
Frequent or severe headaches	☐ Yes ☐ No	
Dizziness/vertigo	☐ Yes ☐ No	
Falls	☐ Yes ☐ No	
Chronic pain (pain longer than 1 month)	☐ Yes ☐ No	
Back or neck problems	☐ Yes ☐ No	
Arthritis	☐ Yes ☐ No	
Osteoporosis or Osteopenia	☐ Yes ☐ No	
A fracture associated with a fall	☐ Yes ☐ No	
Have you ever had or currently have difficulties with daily activities at home, work, or in the community	☐ Yes ☐ No	
Have you ever broken a bone	☐ Yes ☐ No	
Have you had a bone density test	☐ Yes ☐ No	
Numbness/tingling: If yes, indicate where	☐ Yes ☐ No	
Weakness: If yes, indicate where	☐ Yes ☐ No	
Skin Conditions	☐ Yes ☐ No	
Heart attack	☐ Yes ☐ No	
Thyroid issues	☐ Yes ☐ No	
Heart problems	☐ Yes ☐ No	
Chest pain	☐ Yes ☐ No	
Do you have a pacemaker or defibrillator	☐ Yes ☐ No	
Cancer? *If Yes, Please state site and any cancer treatment?*	☐ Yes ☐ No	
HIV or AIDS	☐ Yes ☐ No	
Hepatitis	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Unexplained weight loss or gain	☐ Yes ☐ No	
History wound/ulcers	☐ Yes ☐ No	
Difficulty swallowing	☐ Yes ☐ No	
High Blood Pressure	☐ Yes ☐ No	
Low blood sugar	☐ Yes ☐ No	
Any trouble with bladder/bowel control	☐ Yes ☐ No	
Any pain or difficulty with urination	☐ Yes ☐ No	
Cholesterol problems	☐ Yes ☐ No	
Vision problems	☐ Yes ☐ No	
Ear or hearing problems	☐ Yes ☐ No	
Speaking problems	☐ Yes ☐ No	
Current or past use of tobacco	☐ Yes ☐ No	
Caffeine use	☐ Yes ☐ No	
Alcohol use	☐ Yes ☐ No	
Recreational drug use	☐ Yes ☐ No	
Mental Health Diagnosis: If yes, indicate diagnosis	☐ Yes ☐ No	

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Have you ever had any other major medical problems? If yes, please list: ______________________________

____

When are you scheduled to have another appointment with your physician? ______________________________

Have you or are you scheduled to see other medical professionals or wound care centers regarding your condition? ☐ Yes ☐ No

If yes, please write their name and specialty: ______________________________

____

Have you received Rehabilitation services (PT, OT, SLP) or other treatment for this condition prior to arriving here? ____________

If yes, what type of services and where and when did you receive services? ______________________________

Have you received any other services related to why you are being seen here? ______________________________

Activities of Daily Living:	
Do you depend on others for care(grocery shopping, bathing, housework)?	☐ Yes ☐ No
Do others depend on you for their care? (Small children, older relatives, sick or disabled person, etc.)	☐ Yes ☐ No
Do you live alone?	☐ Yes ☐ No
Do you have steps to get into your home or inside your home? If yes, how many steps _________ and ☐ 1, ☐ 2, or ☐ no rails	☐ Yes ☐ No
Are you currently driving?	☐ Yes ☐ No

Women's Health Questions		Please Explain
Are you pregnant? If yes, how many weeks?	☐ Yes ☐ No	
Have you had an OB/GYN visit in the last year?	☐ Yes ☐ No	
Any complications with pregnancies or deliveries?	☐ Yes ☐ No	

Signature of person completing this form: ______________________________ Date: ________________

If you are not the patient completing this form, what is your relationship to client? ______________________________

Office Use:

Therapist's Signature: ______________________________ Date:______________ Time: ____________am/pm
(Signature indicates review of this information)

Therapist's Signature: ______________________________ Date:______________ Time: ____________am/pm
(Signature indicates review of this information)

Therapist's Signature: ______________________________ Date:______________ Time: ____________am/pm
(Signature indicates review of this information)

Therapist's Signature: ______________________________ Date:______________ Time: ____________am/pm
(Signature indicates review of this information)

Therapist's Signature: ______________________________ Date:______________ Time: ____________am/pm
(Signature indicates review of this information)

Therapist's Signature: ______________________________ Date:______________ Time: ____________am/pm
(Signature indicates review of this information)

Therapist's Signature: ______________________________ Date:______________ Time: ____________am/pm
(Signature indicates review of this information)

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