Middlesex Health

PHYSICAL REHABILITATION

Name: _____ Date of Birth: _____

Reason for Seeking Therapy: _____

Date Symptoms Began? _____ Preferred Language: ❑ English ❑ Spanish ❑ Polish ❑ Other: _____

Past Medical History (Please check all that apply):

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Bowel/Bladder problems
- ❑ Blood Pressure problems
- ❑ Cancer
- ❑ Clotting Disorder
- ❑ Depression
- ❑ Diabetes
- ❑ Dizziness
- ❑ DVT
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ GERD
- ❑ Headaches
- ❑ Hearing problems
- ❑ Heart problems
- ❑ Hepatitis
- ❑ High Cholesterol
- ❑ Kidney problems
- ❑ Liver disease
- ❑ Lung problems
- ❑ Neurological disorder
- ❑ Pancreatic Disease
- ❑ Psychological problems
- ❑ Swelling/edema
- ❑ Sleep Disorder
- ❑ Thyroid Disorder
- ❑ Vision Problems
- ❑ Weight Changes
- ❑ Wounds
- ❑ Other: _____
- ❑ _____

Surgical History and Hospitalizations: ❑ None

_____

Medications: ❑ None ❑ Copy provided/see attached _____

_____

_____

Allergies: ❑ None _____

Pain Scale: Rate your pain today (circle): **0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10**
No pain Worst pain

Goals and Consent

At the end of my first visit, my therapist and I will discuss treatment options, including risks, benefits, and plans for treatment.

I understand that my therapist and I will work together to meet these goals. I will need to:

- Keep all of my appointments, or call at least 24 hours in advance if I need to cancel. If I miss two appointments in a row without calling to cancel, my name will be taken out of the schedule and I will need a new doctor's referral to continue therapy. If I am on worker's compensation and miss my appointment, my employer can be notified. If I am late for my appointment, my therapist may see me if there is enough time in the schedule. I may receive care from another therapist if my therapist is unavailable.
- Do my home exercises and follow any instructions that my therapist gives me.
- Tell my therapist if I have any changes in health and/or medication, or if I see another doctor for the same condition.

My therapy will end when I have met all my goals or when my therapist and I find that we have reached the highest possible benefit of therapy. Therapy can also end due to a change in my health, lack of insurance, or if I stop coming for treatment.

My Goals for Therapy: _____

Patient / Guardian Signature	**Date**	**Time**

For Office Use Only:

SAFETY/FALL RISK: ❑ Age 65 or Older ❑ 3 or more co−existing diagnoses ❑ History of falls within 3 months ❑ Incontinence ❑ Visual Impairments ❑ Impaired Functional Mobility ❑ 4 or more medications ❑ Cognitive Impairment ❑ Pain Affecting Function

SCORE: _____ (4 or more = risk of falling)

Therapist Signature	**Date**	**Time**