OSF
SAINT FRANCIS
MEDICAL CENTER

Illinois
Neurological
Institute

Name ____
DOB ____
MRN ____
PHYS____

Outpatient Rehabilitation Patient Health History

TO BE COMPLETED BY PATIENT: (please check)

CVA (Stroke): □ Yes □ No
Cancer □ Yes □ No
TBI (Traumatic Brain Injury □ Yes □ No
Chronic Respiratory □ Yes □ No
Seizure □ Yes □ No
Asthma □ Yes □ No
Heart Disease □ Yes □ No
Osteoporosis □ Yes □ No
Metal Implants/Pacemaker □ Yes □ No

Pacemaker □ Yes □ No
Bowel/Bladder □ Yes □ No
High Blood Pressure □ Yes □ No
Pregnant □ Yes □ No
Diabetes Mellitus □ Yes □ No
Tuberculosis □ Yes □ No
Do you smoke? □ Yes □ No
Would you like information to help stop smoking? □ Yes □ No

Do you have an allergy to latex? □ Yes □ No

To adhesive tape? □ Yes □ No

Other allergies, including medication allergies:
____
____

Would you like information regarding advance directives (power of attorney for health care)?
□ Yes □ No
Do you have any current or recent problems with use of alcohol, controlled substances or prescription drugs? □ Yes □ No If you do, please tell us so that we can assist you.

Do you have any dietary restrictions (such as soft diet. thickened liquids)?
____
____

Do you or your key caregivers have any special accommodations needed/preferred learning style (such as demonstration, reading, discussion, Internet. etc.) ?
____
____

Do you or your key caregivers have any special cultural/religious needs we should be aware of?
____
____

Surgeries? □ Yes (please list) □ No:
____

Orthopedic injuries/conditions? □ Yes (please list) □ No:

____

Have you received previous therapy for your current condition? □ Yes □ No
When? ____
Where? ____
Are you currently receiving any other kind of treatment for this condition? □ Yes □ No
Please describe:

____

HOME ENVIRONMENT:
Are you currently living alone or with someone? _____________________________________
Can they physically help you, if needed? □ Yes □ No □ N/A
If yes, who? ____ Hrs per day____________________
Do you receive help from family or an aide? □ Yes □ No □ N/A
If yes, who? ____ Hrs per day____________________
Are you living in your own home or with someone temporarily?

____

Do you have stairs? □ Yes □ No If yes, how many? ______ Do you have a rail? □ Yes □ No
Do you have a walk-in shower or tub shower? ____
What bathroom equipment do you have to assist you?

____

Medications you are currently taking (or please attach list):

____
____

Do you (or your family members) need any information we have not provided? If so, please tell your therapist and explain here:

____
____
____
____
____
____