Name MRN DOB (Patient Identification)	VCU Health Community Memorial Hospital **Physical Therapy & Occupational Therapy Intake**

Hendrick Cancer & Rehab Center
750 Lombardy Street, P.O. Box 90
South Hill, VA 23970

**Please complete this form. Some questions may not seem relevant to your care but are a requirement.*

Name: _____ Date: _____

Date of Injury or Surgery: _____ If surgery, performed by: _____

Briefly describe why you came to therapy: (Illness, Surgery, Medical Condition)

_____

_____

_____

Have you had therapy for the same injury before? ☐ Yes ☐ No

Environment: Tell us about where you live:

☐ House
☐ Apartment
☐ Mobile home
☐ Residential/ Group
☐ Temporary
Other: _____

How many stories? _____
Basement? ☐ Yes ☐ No
How many steps? _____
Are there railings? ☐ Yes ☐ No

Who lives with you?

☐ Alone
☐ Spouse/Partner
☐ Parent(s)
☐ Children (young)
☐ Children (adult)
☐ Grandchildren
☐ Roommate
☐ Caregiver
☐ Pets

Do you feel safe in your home? Yes _____ No _____

Mobility: what devices do you use to move around?

☐ Nothing
☐ Cane
☐ Quad Cane
☐ Walking stick
☐ Walker
☐ Hemi-walker
☐ Rolling walker
☐ Crutches
☐ Wheelchair
☐ Power wheelchair
☐ Forearm crutches
☐ Other

DME: Check if you have the following:

☐ Shower seat
☐ Grab bars
☐ Handheld shower
☐ Hospital Bed
☐ Wheelchair ramp
☐ Toilet riser/bedside commode
☐ Stair lift
☐ Reacher/sock aide

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Do you have slings, splints, braces or prosthetics? Please describe. _____

_____

Medical History: Check all the conditions you have ever been diagnosed with. (Limited examples shown)

- ☐ Arthritis - if so, where?
  _____
  _____
  _____
- ☐ Osteoporosis
- ☐ Broken Bone/ Fractures
  _____
  _____
  _____
- ☐ Cancer - if so, where?
  _____
  _____
  _____
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Sleep Problems
  Apnea, CPAP
- ☐ Diabetes
  high blood sugar
- ☐ Hypoglycemia
  low blood sugar
- ☐ Heart Problems
  Atrial fibrillation
  Congestive Heart Failure (CHF)
- ☐ Cardiac Device
  Pacemaker, Loop recorder,
  Implantable cardiac defibrillator (ICD)
- ☐ High Blood Pressure
- ☐ Breathing problems
  COPD, Asthma
- ☐ Thyroid problems
- ☐ Blood Disorder
  Sickle Cell, Anemia
- ☐ Infectious Disease
  HIV, TB, Hepatitis
- ☐ Mental Health Problems
  Depression, Anxiety, Bipolar
  PTSD, Schizophrenia
- ☐ Long COVID

Other_____
_____

- ☐ Stroke or CVA
- ☐ Head Injury or TBI
- ☐ Tremors
  Parkinson's Disease
  Essential
- ☐ Seizures/Epilepsy
- ☐ Learning Disability
- ☐ Cerebral Palsy
- ☐ Autism Spectrum
- ☐ Balance Problems
- ☐ Stomach Problems
  Ulcer, Crohn's
- ☐ Kidney Problems
  Dialysis
  Chronic Kidney Disease
- ☐ Bowel or Bladder Problems
- ☐ Multiple Sclerosis
- ☐ Skin Disease

Other _____
_____

Check all the conditions you had in the last year.

- ☐ Pregnancy
- ☐ Weight gain/loss
- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Shortness of breath
- ☐ Dizziness or blackouts
- ☐ Difficulty walking
- ☐ Balance problems
- ☐ Coordination problems
- ☐ Difficulty Sleeping
- ☐ Weakness arm or legs
- ☐ Bowel/bladder changes
- ☐ Frequent Headaches
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Tobacco use
- ☐ Alcohol use
- ☐ Drug use

Allergies: List your allergies (medication, Latex, food, etc.) _____

_____

Surgery: List past surgeries and date is was performed.

_____ _____
_____ _____
_____ _____

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Medications: Please list all medications – prescribed by doctor and over the counter.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

PAIN/DISCOMFORT:

Please circle number to indicate your current pain level.

0 1 2 3 4 5 6 7 8 9 10

None Mild Moderate Severe Worst possible

How do you relieve the pain/discomfort?

☐ Cold ☐ Heat ☐ Rest ☐ TENS ☐ Ointment

☐ Medicine (prescription) ☐ Medicine (over the counter) Other _____

What makes your pain/discomfort worse? _____

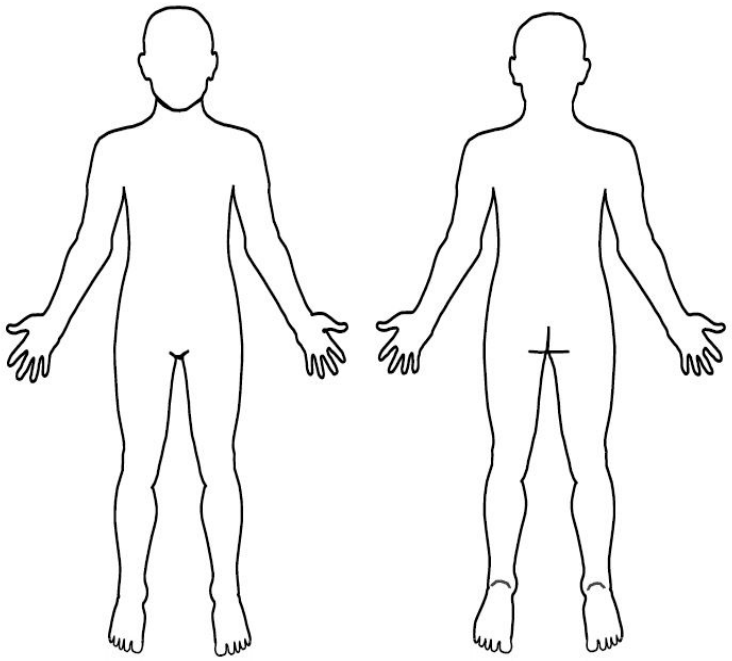
_____

On the figures below, mark where you feel discomfort. Use this key:

XXX = Pain /// = Tingling 000 = Numbness

= Pins & Needles … = Burning

Front



Back

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Suicide Screen: (required)

In the last 2 weeks, on one or more occasion, have you felt down, depressed or hopeless?

☐ YES ☐ NO

In the past 2 weeks, on one or more occasion, have you had little interest or pleasure in doing things?

☐ YES ☐ NO

Legal: Is this referral to therapy related to a lawsuit, Workers Compensation, or a Motor Vehicle Crash?

☐ YES ☐ Lawsuit ☐ Worker's Compensation ☐ Motor Vehicle Crash

☐ NO

Employment: What is your current work situation?

☐ Full Time ☐ Retired

☐ Part Time ☐ Student

☐ Off work ☐ Unemployed

☐ Disability ☐ Medical Leave

Describe your work: _____

FALLS: *A fall is an unintended descent when a hand, knee or hip touches the ground.*

How many times have you fallen in the last 12 months? _____

Is there anything else we should be aware of to achieve a successful therapy experience? _____

_____

_____

Falls Efficacy Scale *(OT Only)*

On a scale from 1 to 10, with 1 being very confident and 10 being not confident at all, how confident are you that you do the following activities without falling?

Activity	Confidence									
	I would NOT fall				**I might fall**				**I would fall**	
Take a bath or shower	1	2	3	4	5	6	7	8	9	10
Reach into cabinets or closets	1	2	3	4	5	6	7	8	9	10
Walk around the house	1	2	3	4	5	6	7	8	9	10
Prepare meals – Not requiring carrying heavy or hot objects	1	2	3	4	5	6	7	8	9	10
Get in and out of bed	1	2	3	4	5	6	7	8	9	10
Answer the door or telephone	1	2	3	4	5	6	7	8	9	10
Get in and out of a chair	1	2	3	4	5	6	7	8	9	10
Getting dressed and undressed	1	2	3	4	5	6	7	8	9	10
Personal grooming (i.e. washing your face)	1	2	3	4	5	6	7	8	9	10
Getting on and off the toilet	1	2	3	4	5	6	7	8	9	10
Total Score										

Adapted from Tinetti et al (1990)