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PATIENT INFORMATION



This is part of your medical record and is strictly confidential. Interpreters and TDD equipment are available.

Instruction:

Please alert the therapist to any changes in this information at your next therapy session.
 To best meet your needs, please take a few minutes to complete this form.
 If there are any questions you don't know how to answer, please discuss them with your therapist.

Height: _____ Wt: _____
 Currently working _____ Yes _____ No Occupation _____
 Current activity limitations _____

List any activities that your doctor has told you not to do at the present time
 _____ Lift more than _____ lbs _____ Twisting _____ Climbing _____ Other
 _____ Bending _____ Reaching _____ Kneeling

Do you use any assistive devices ie: (walker, sling/brace, wheelchair) yes no Type: _____

Do you have any **safety** issues you would like to discuss? yes no Comments: _____

Date when problems began or became significantly worse: _____
 How did it start? _____
 Since it began, is it (please check) better? same? worse?
 What makes your problem worse? _____
 What makes your problem better? _____

Are you currently receiving rehabilitation services anywhere else? yes; no
 Have you had rehabilitation before? yes; no; If yes, when? _____ Where? _____
 For what purpose? _____

Have you had home health services in the past 3 months? yes; no; If yes, when? _____
 What agency? _____ For what purpose? _____

Medications:

Please list any medications you are currently taking (include both prescriptions over-the-counter medications, vitamins, herbal remedies, topical ointments).

NAME	DOSAGE	FREQ/TAKEN	REASON TAKING MEDICATION

Allergies: no known yes list: _____

Any allergies to medications?

LIST MEDICATION	REACTION TYPE	COMMENT

To other substances (ie latex)? List: _____

Medical tests: (Please give date of last test)

Xray: _____ MRI: _____ Myelogram: _____ CT scan: _____ EMG: _____

Doppler: _____ Ultrasound: _____ Mammogram: _____ Other: _____

Have you had any injections for your current condition: yes no Location: _____



**REHABILITATIVE SERVICES
 DEPARTMENT
 PATIENT INFORMATION**

Patient Label



HNMTR

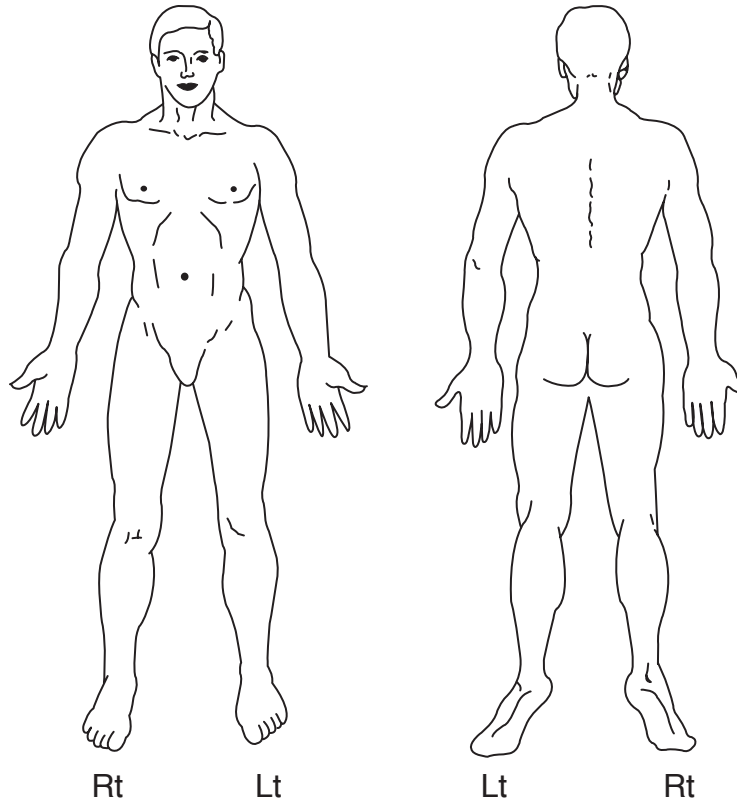
Do you have pain associated with your condition? Yes No

Please help us evaluate your pain by completing the following pain diagram

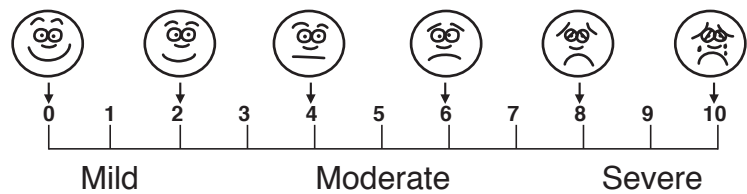
DIRECTIONS: MARK AREAS THAT CAUSE YOU PAIN
Use the following letters to mark type/location of pain

Pain Description:

- A. Sharp
- B. Dull
- C. Ache
- D. Throb
- E. Heavy/Full
- F. Tingling
- G. Numb
- H. Radiating down arm/leg
- I. Other: _____



PLEASE RATE YOUR OVERALL PAIN



PATIENT SIGNATURE

DATE



REHABILITATIVE SERVICES
DEPARTMENT
PAIN DIAGRAM

Patient Label



HNMTR

Our goal in the Rehabilitative Services Department at Houston Northwest Medical Center is 100% customer satisfaction. To better serve your needs, we may need to be able to contact you during the day.

Please list the best way to reach you during the day. If you prefer we do not call, please indicate by writing "don't call".

Home phone: _____

Work phone: _____

Cell phone: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY:

NAME: _____ PHONE: _____

You are encouraged to discuss therapy services, benefits, expected outcome, risks and alternatives concerning your treatment plan with your therapist.

As a courtesy to you and your busy schedule, we will be glad to schedule you for the full duration of your plan of care. In order for you to achieve maximum benefits from your therapy, please adhere to all scheduled appointments. If you need to reschedule, please call the department at least 12 hours before your appointment time, and we will be glad to reschedule you. We will give you a print out of all your appointment times.

IF YOU NO SHOW FOR AN APPOINTMENT, YOUR FUTURE APPOINTMENT TIMES WILL BE CANCELLED.

Thank You,
YOUR THERAPY PROVIDERS

PATIENT SIGNATURE

DATE



**PATIENT CONTACT
INFORMATION**

Patient Label