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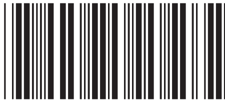


Quest

BOZEMAN HEALTH
DEACONESS HOSPITAL

Patient Label
Name: ___________________
DOB: _____________________
M#:______________________

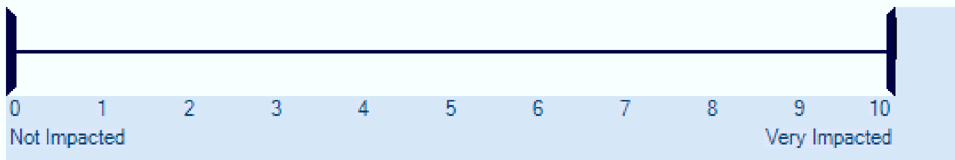
Bozeman Health Deaconess Physical Rehabilitation Services Patient Intake Form

What is your primary concern/reason for seeking Physical/Occupational/Speech Therapy Services?
(Circle all that apply)

- Pain
- Headache
- Joint Stiffness
- Joint Swelling
- Muscle Tenderness
- Muscle Weakness
- Balance Problems
- Difficulty with walking
- Falls
- Fatigue/Poor Endurance
- Difficulty with Daily Activities
- Numbness/Tingling
- Difficulty Manipulating Small Objects
- Difficulty Driving
- Vision Problems
- Coughing/Choking with Swallowing
- Difficulty with Communication
- Difficulty with Memory/Attention
- Difficulty with Urinary/Bowel Incontinence
- Difficulty with Urinary Urge
- Pelvic Pain
- Other:_______________

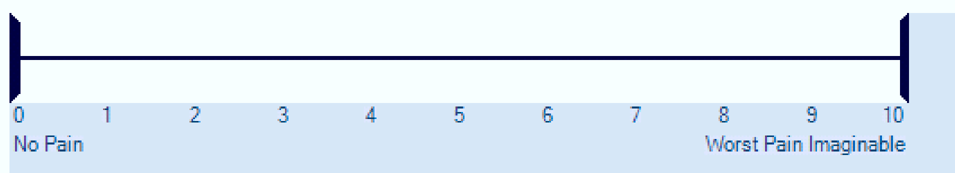
Is this condition a work-related injury? Yes No Unknown
Is this condition related to an accident? No Yes—at work Yes—at home Yes—motor vehicle Yes—Other
Please list any other medical providers who are providing treatment for this condition:

Please rate the severity of your condition in regard to impact on your normal daily activities:



Do you have pain related to the condition from which you are seeking therapy services? Yes No

If Yes, **Pain Level—average over past week**



Pain Location:

- Head/Neck
- Back
- Upper Extremity R/L
- Lower Extremity R/L
- Shoulder R/L
- Elbow R/L
- Wrist R/L
- Hand R/L
- Hip R/L
- Knee R/L
- Ankle R/L
- Foot R/L
- Pelvic

Have you participated in other Physical, Occupational, or Speech Therapy services this past year? Yes No

What is the frequency of pain? ○ **0-25%** ○ **26-50%** ○ **51-75%** ○ **76-100%**

Medical History—please circle all that apply

- Broken Bones/fracture
- Osteoporosis
- Arthritis
- Tuberculosis/Hepatitis
- HIV/AIDS
- Heart Problems
- Lung/Breathing Problems
- High Blood Pressure
- Fibromyalgia
- Stroke/Head Injury
- Neurological Disorder
- Epilepsy/Seizure Disorder
- Mental Health Diagnosis
- Cancer
- Diabetes
- Circulation/Vascular Problems
- History of Blood Clot
- Pregnant
  Due Date___________
- Previous Surgeries:
  ____
  ____

Do you have any of the following within your body?

- None
- Pacemaker/Defibrillator
- Pain Pump
- Neurotransmitter
- Baclofen Pump
- Rods/Pins/ Staples
- Artificial Joints
- Metal from Gun Shot Wound
- Implants
- Other: ____________

Allergies

- Food items:
- Medications (please list):
- Latex
- Adhesives
- Other________________
- Other ________________

Rate your general health: Excellent Very Good Good Fair Poor
Smoking Status: Current Smoker Former Smoker Never Smoked
Activity Level: Contact Sport Highly Aerobic Moderately Aerobic Sedentary, but active Sedentary
Recreation/Leisure Activities:

Employment Status:

- Retired
- Full Time
- Part Time
- Not Working Due to Injury
- Working Restricted Duty/Hours Due to Injury
- Homemaker
- Student
- Volunteer
- Unemployed

If Employed,

Occupation:
Work Stresses:

- Prolonged Sitting
- Prolonged Standing
- Prolonged Computer Work
- Repetitive Lifting
- Repetitive Movements
- Manual Labor
- Maximum weight you push/pull: _________
- Maximum weight you lift/carry: _________

Bozeman Health Deaconess Health Care Services is accredited by the DNV on Accreditation of Healthcare Organizations. As such, the following questions are asked to help ensure that all of your needs are being met and appropriate referrals can be made if desired.

Have you had any falls in the last year? Yes No

Have you experienced a significant change in weight? Yes No

If Yes:

# of Pounds	Gain/Loss	Time Frame	Purposeful?	Physician Aware?
	Gain/Loss		Yes/No	Yes/No

How do you learn best? Pictures Reading Listening Demonstration

Do you have difficulty with any of the following:

- Hearing
- Vision
- Reading
- Understanding what is read
- Language—interpreter needed
- Other: _____________

Have you experienced neglect or abuse? Yes No

If yes, would you like to speak to someone about this? Yes No

Do you have any preferences, cultural, or religious beliefs that may affect your care? Yes No

If Yes, please explain: