Berkshire Health Systems, Inc.

REHABILITATION SERVICES
PATIENT HEALTH SUMMARY

patient sticker

- What problem brings you to therapy today? ____
____
____

- When did this episode of symptoms/problems start? (Date): ______________________________

- Are your symptoms: (check one) **1)** Getting worse ____ **2)** Staying the same ____ **3)** Improving ____

- What are you currently having trouble doing because of your present condition?
____
____

- What are your therapy goals? (Check all that apply).

  ___Increase my activity level
  ___Get a home exercise program
  ___Reduce my pain
  ___Improve my sports performance
  ___Return to work
  ___Learn about my problem and how to manage it
  ___Get a diagnosis and/or prognosis for my condition
  ___Improve self-care ability
  ___Other:
  ____

- Have you already tried any other kind of treatment for the condition that brings you to us today?
  No____ **Yes**____ If yes, please list:
____
____
____

- Tests you have had for this condition (such as x-rays, MRI, CT Scans, etc.):
____
____
____

Do we have permission to leave a voice message about your appointments?
YES_______ **NO______**

*****Over*****

- Medications you are currently taking: (Please include vitamins / supplements as well as over the counter medicine - attach additional sheet if needed).

____
____
____

- Do you have any allergies or sensitivities to medications, foods, or bee stings, etc.?
  No ____ **Yes**____ - if yes please list

____
____

- Past Hospitalizations and surgeries:

____
____
____

- Other past/current medical conditions: (Please check all that apply)

___ Diabetes
___ Cancer
___ Fractures
___ Pacemaker
___ Heart Attack
___ Angina
___ High or low blood pressure
___ Asthma
___ Congestive Heart Failure
___ Smoking history
___ Blood Clots
___ Open Wounds
___ Bleeding Disorders
___ Epilepsy/Seizures
___ Fainting/Dizzy Spells
___ Thyroid Disorder
___ Hearing or vision problems
___ Currently or possibly pregnant?
___ Depression/Anxiety/PTSD
___ Other:
___ Arthritis
___ Back/Neck Injury
___ Metal implants
___ Osteoporosis
___ Fibromyalgia
___ Head Injury / concussion
___ Headaches
___ Stroke
___ Memory problems
___ Swallowing difficulty
___ Infections
___ Tuberculosis
___ Hepatitis
___ Kidney Disease
___ Incontinence
___ Alcohol/Drug use
___ Glaucoma
___ MS/MD/ALS
___ Parkinson's Disease

____

- Is there anything about your home life that makes you feel threatened?
  No____ **Yes**____

By signing below, you certify that the above information is correct, to the best of your knowledge, and that you have received the rehabilitation orientation pamphlet.

Date: ________Time:_____Patient/parent/ guardian Signature: ______________________________