Shirley Ryan Abilitylab

Outpatient Therapy Medical Intake Form

Name:_____ **FIN#:**_____
Attending Physician: _____ **MR#**_____
(for office use only)

CLEAR FORM

Name: _____ Pronouns: _____ Date: _____

Primary Care Physician: _____ Phone: (_____)_____ Hospital Affiliation: _____

Referring Physician: _____ Phone: (_____)_____ Hospital Affiliation: _____

What is the reason for your appointment? _____

What are your goals for therapy ? _____

Please list any personal preferences that may impact your therapy (spiritual, cultural, communication style, learning style):

_____

If you have a form with your wishes for CPR or other life sustaining treatment, please bring it to your appointment.

PAIN

Do you have pain? ☐ Yes ☐ No If yes:

What makes it better? _____

What makes it worse? _____

List three activities that are limited by your pain:

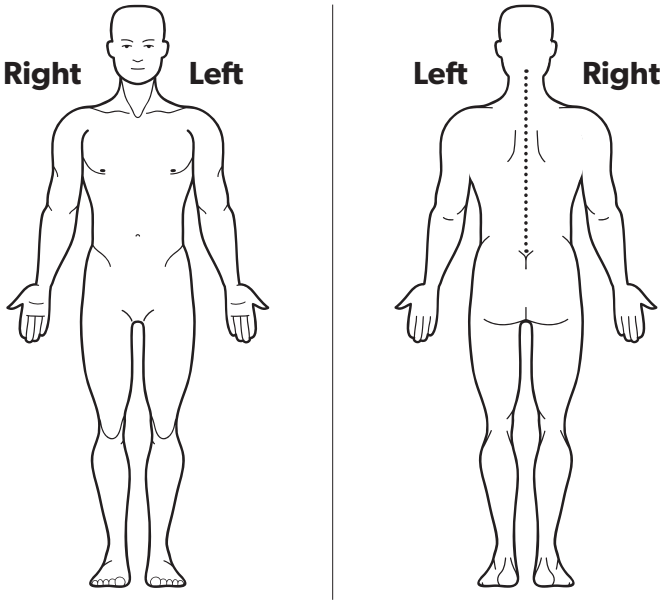
1. _____
2. _____
3. _____

Please check a number below to indicate the level of pain you currently have:

No pain — Worst pain imaginable

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

Shade the areas below where you have pain:



PAST MEDICAL HISTORY: Have you ever been diagnosed as having the following conditions:

☐ Yes ☐ No	Asthma
☐ Yes ☐ No	Blood clots
☐ Yes ☐ No	Cancer: What type? _____
☐ Yes ☐ No	Chemical dependency (e.g., alcoholism)
☐ Yes ☐ No	Chronic obstructive pulmonary disease
☐ Yes ☐ No	Circulation problems
☐ Yes ☐ No	COVID-19
☐ Yes ☐ No	Depression/Anxiety
☐ Yes ☐ No	Diabetes
☐ Yes ☐ No	Fractures
☐ Yes ☐ No	Heart problems: What type? _____
☐ Yes ☐ No	Hepatitis
☐ Yes ☐ No	High blood pressure
☐ Yes ☐ No	Kidney disease
☐ Yes ☐ No	Multiple sclerosis
☐ Yes ☐ No	Osteoporosis
☐ Yes ☐ No	Rheumatoid arthritis
☐ Yes ☐ No	Other arthritic conditions
☐ Yes ☐ No	Stomach ulcers
☐ Yes ☐ No	Stroke
☐ Yes ☐ No	Thyroid problems
☐ Yes ☐ No	Tuberculosis
☐ Yes ☐ No	Other: _____

Please continue on the next page.

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Please list any surgeries or other conditions for which you have been hospitalized, including the date and reason for the surgery or hospitalization:

_____

_____

_____

ALLERGIES

List any allergies to medications: _____

Are you latex sensitive? ☐ Yes ☐ No

FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following:

☐ Yes ☐ No Cancer
☐ Yes ☐ No Depression
☐ Yes ☐ No Heart disease
☐ Yes ☐ No High blood pressure
☐ Yes ☐ No Inflammatory arthritis (rheumatoid, ankylosing)
☐ Yes ☐ No Kidney disease
☐ Yes ☐ No Multiple sclerosis
☐ Yes ☐ No Neurologic condition
☐ Yes ☐ No Stroke

DAILY ACTIVITIES/HEALTH HABITS

Have you ever been diagnosed with any of the following: ☐ MRSA ☐ VRE ☐ Cdiff ☐ Tuberculosis

Do you use tobacco? ☐ Yes ☐ No Packs/day: _____ # years _____ If quit, when? _____

How many alcoholic beverages do you drink per week? _____

Do you use street drugs? ☐ Yes ☐ No If yes, which ones? _____

How many caffeinated beverages do you drink per day? ☐ 0–1 ☐ 2–4 ☐ 5 or more

What is your current occupation? _____

Current employment status: ☐ Full time ☐ Part time ☐ Retired ☐ On disability leave ☐ Unemployed

In what leisure activities, hobbies and/or exercise regimens do you participate? _____

_____

Please check the box of any of the following symptoms/signs that you are currently experiencing:

☐ Weight loss/gain
☐ Nausea
☐ Vomiting
☐ Dizziness/lightheadedness
☐ Fatigue
☐ Unusual weakness
☐ Fever/chills/sweats
☐ Numbness or tingling
☐ Tremors
☐ Seizures
☐ Night sweats
☐ Chest pain
☐ Heart racing in your chest
☐ Abdominal pain
☐ Heartburn/Indigestion
☐ Difficulty breathing/shortness of breath
☐ Regular/persistent cough
☐ Recent infection
☐ Diarrhea
☐ Constipation
☐ Bowel incontinence
☐ Blood in stools
☐ Post-menopause
☐ Problems urinating
☐ Urinary incontinence
☐ Urinary urgency
☐ Urinary frequency
☐ Urinary retention requiring catheterization
☐ Blood in the urine
☐ Pregnant or think you might be pregnant
☐ Skin rash
☐ Excessive bleeding
☐ Easy bruising
☐ Unusual joint/muscle swelling
☐ General arm/leg swelling
☐ Loss of sensation
☐ Hearing problems
☐ Difficulty speaking
☐ Difficulty swallowing
☐ Stress at home or work
☐ Double vision
☐ Loss of vision
☐ Unusual eye redness
☐ Problems sleeping
☐ Sexual difficulties

☐ **I do not have any of the signs or symptoms listed above.**

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Abilitylab

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Please do not complete if you have submitted a copy of your medication list at any Shirley Ryan AbilityLab location within the past month.

MEDICATION LIST

Please list your medications, including supplements and vitamins:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____