SAN ANTONIO REGIONAL HOSPITAL

REHABILITATION SERVICES
OUT-PATIENT SUMMARY LIST

PATIENT NAME: _____ DATE: _____

1. **DO YOU HAVE A HISTORY OF ANY RESISTANT BACTERIA, SUCH AS MRSA, VRE, C-DIFF? _____**YES _____NO
   (Office use ONLY) IF YES, NOTIFY INFECTION CONTROL NURSE

2. **KNOWN DIAGNOSIS AND CONDITIONS (please circle your medical conditions on page 4):**
   (Office use ONLY) DATE: _____ UPDATES: _____

3. **KNOWN SIGNIFICANT SURGICAL AND INVASIVE PROCEDURES (please list below):**

   _____

   _____
   (Office use ONLY) DATE: _____ UPDATES: _____

4. **CURRENT MEDICATIONS, OTC AND HERBAL MEDICATIONS (please list on page 5):**
   (Office use ONLY) DATE: _____ UPDATES: _____

5. **KNOWN ADVERSE AND ALLERGIC DRUG REACTIONS (please list below):**

   _____

   _____
   (Office use ONLY) DATE: _____ UPDATES: _____

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OUT-PATIENT INFORMATION/
MEDICAL HISTORY

NAME_____ TODAY'S DATE_____

OCCUPATION _____

WORKING (Circle One): YES / NO DUE TO INJURY / DO NOT WORK / RETIRED

REASON FOR PHYSICAL THERAPY:_____

WHEN DID YOUR PROBLEM START:_____

EMERGENCY CONTACT: NAME_____PHONE#_____

FUNCTIONAL PROBLEMS (please circle only those that apply to your current diagnosis):

Sitting	Squatting	Reaching/Raising Arms	Turning Head
Standing	Sleeping	Driving	Speech
Walking	Dressing	Working	Swallowing
Stairs	Bathing	Lifting	Coughing
Bending	House Chores	Transferring sitting to standing	Memory

- Explain any other functional problems you may have due to this diagnosis: _____

_____

PAIN LEVEL

- What level of pain does your current condition cause you? (please circle the number(s) below that apply)

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst imaginable pain

- What word(s) best describe your pain (please circle any that apply):
  dull aching sharp burning Other_____

- Do you also experience any other symptoms such as (please circle any that apply):
  tingling numbness stiffness weakness Other_____
- What do you hope to gain from treatment? _____

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OUT-PATIENT INFORMATION/
MEDICAL HISTORY

MEDICAL TESTING

Have you had any x-rays, sonograms, CT scans, MRI done recently? _____Y _____N (If yes, at which facility did you have them done and what were the results?)_____

_____

Are you currently seeing any of the following?

Psychiatrist/Psychologist _____Y _____N Chiropractor _____Y _____N

Occupational therapist _____Y _____N Speech therapist _____Y _____N

THERAPY HISTORY

******Are you currently receiving home health nursing or therapy?** ____Y _____N

******Please state if you have received out-patient physical, occupational or speech therapy anytime earlier this year.** _____

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OUT-PATIENT INFORMATION/
MEDICAL HISTORY

PAST MEDICAL HISTORY: Have you ever been told you have any of the following?

	Circle one
1. Cancer	YES NO
2. Diabetes	YES NO
3. Osteoporosis	YES NO
4. Arthritis	YES NO
5. High blood pressure	YES NO
6. Heart disease	YES NO
7. Angina / chest pain	YES NO
8. Shortness of breath	YES NO
9. Stroke	YES NO
10. Currently Pregnant	YES NO
11. Asthma	YES NO
12. Abnormal heart rhythm	YES NO
13. Metal Implants	YES NO
14. Chronic bronchitis	YES NO
15. Pacemaker	YES NO
16. Emphysema	YES NO
17. Seizures / epilepsy	YES NO

18. Any other medical issues (please explain) _____

- When is your next appointment with the doctor who sent you here? _____

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OUT-PATIENT INFORMATION/
MEDICAL HISTORY

MEDICATION LOG

Today's Date	Medication Name	List the condition the medication is for	Dosage

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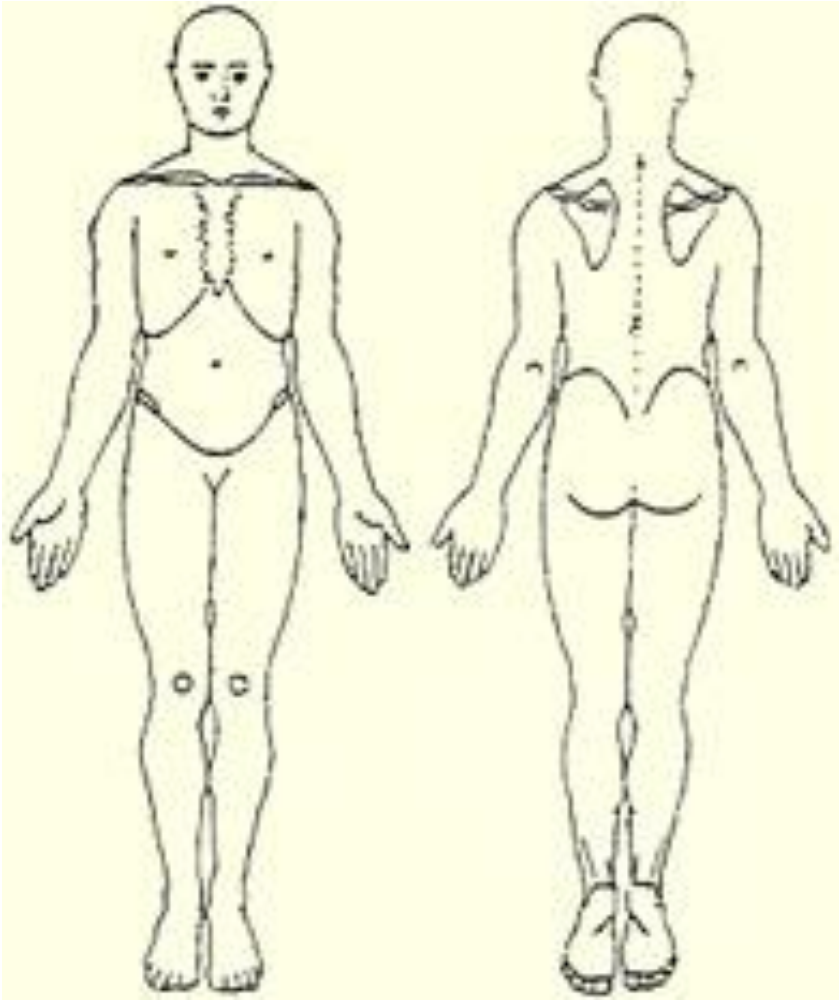
OUT-PATIENT INFORMATION/
MEDICAL HISTORY

Body Chart

Please mark the areas on the body chart where you are having problems/ symptoms.



Signature:_____ **Date**:_____