ORLANDO HEALTH | South Lake Hospital
In affiliation with Orlando Health

REHABILITATION SERVICES OUTPATIENT HISTORY

Patient Identification

We are a 911 facility. In case of emergency, 911 will be contacted.

Do you have any of the following? □ YES □ NO
If So □ Advanced Directive □ Living Will □ DNR □ Medical Power of Attorney

Copy Provided? □ YES □ NO

Emergency Contact Information: Name:_____

Relationship to Patient:_____ Phone Number:_____

1. Preferred language for discussing healthcare information:_____
2. Reason for Therapy:_____
3. Referring Physician:_____
4. Have you ever been an inpatient or outpatient at an Orlando Health facility before? ☐Yes ☐No
   If yes, when_____, where_____
   and for what reason?_____
5. Have you had Physical, Occupational or Speech Therapy before? ☐Yes ☐No
   If yes, which one(s): ☐Physical ☐Occupational ☐Speech
   Why?_____
   Where?_____, When?_____
6. Please list your current medications:_____
   _____
   _____
7. Do you have any allergies (medication, food, latex contact, environmental) ? ☐Yes ☐No
   (If yes, please list) _____
   _____
8. Do you react abnormally to heat or cold applications? ☐Yes ☐No
   If yes, please check all that apply: □ Pain □ Sweating □ Skin Discoloration □ Excessive Chills
   □ Shortness of Breath □ Nausea □ Increased Blood Pressure or Pulse □ Dizziness □ Welts
   □ Other:_____
9. Have you been told that you have any of the following diseases or symptoms? ☐Yes ☐No
   (Please check all that apply and provide dates where possible):

☐High Blood Pressure	_____	☐ Emphysema/Bronchitis	_____
☐Heart Conditions	_____	☐ Hepatitis	_____
☐Diabetes	_____	☐ Cancer	_____
☐Fainting Spells	_____	☐ Dizziness	_____
☐Stroke	_____	☐ Allergies	_____
☐Seizures	_____	☐ AIDS	_____
☐Vascular Problems	_____	☐ Other infectious diseases	_____

10. Please list any other diseases or disorders you may have: _____
    _____
    _____
    _____

Staff Initial:_____ Date/Time:_____

11. If you are female, are you **pregnant**? ☐Yes ☐No
12. Do you have **metal** in your body? ☐Yes ☐No
13. Have you had a recent exposure to any Communicable **Diseases**? ☐Yes* ☐No
    If yes, please specify: ☐Chicken Pox ☐Measles ☐Mumps ☐Other:_____
    Date of Exposure:_____
14. Do you have a history of **MRSA** or **VRE** (multi-drug resistant organisms): ☐Yes ☐No
15. Have you ever had any of the following **surgical procedure(s)**? ☐Yes ☐No
    if yes, at what hospital or facility, why, and when?
    Artificial joints_____
    Pacemaker_____
    IUD_____
    Wires, screws, nails, or other metal implants_____
    Other_____
16. Briefly explain if you are having difficulty with:
    Sleeping_____
    Caring for self_____
    Working_____
    Social activities_____
    Shopping_____
    Housework_____
    Yard Work_____
    Other_____
17. Have you had any falls in the last 3 months? ☐Yes ☐No
18. Is there a history of or current sexual, emotional, or physical abuse or domestic violence?
    ☐No ☐Yes: ☐Current ☐History --- if yes, staff can provide information (SLH policy 200.221)

ATTENTION: For our female patients: If at any time you suspect you are pregnant, please let your clinician know.

CANCELLATION / NON-ATTENDANCE POLICY:

I understand that following three missed appointments therapy may be discontinued secondary to lack of attendance. If I am 15 minutes late, my appointment time may not be guaranteed.

NOTICE: In the event that your insurance benefits have been exhausted, you have the following options:

1. To continue your therapy (self-pay) -or-
2. Step Over Program (independent wellness program)

Payment is required at the time services are rendered.

Patient/Patient Representative Signature:_____ Date:_____

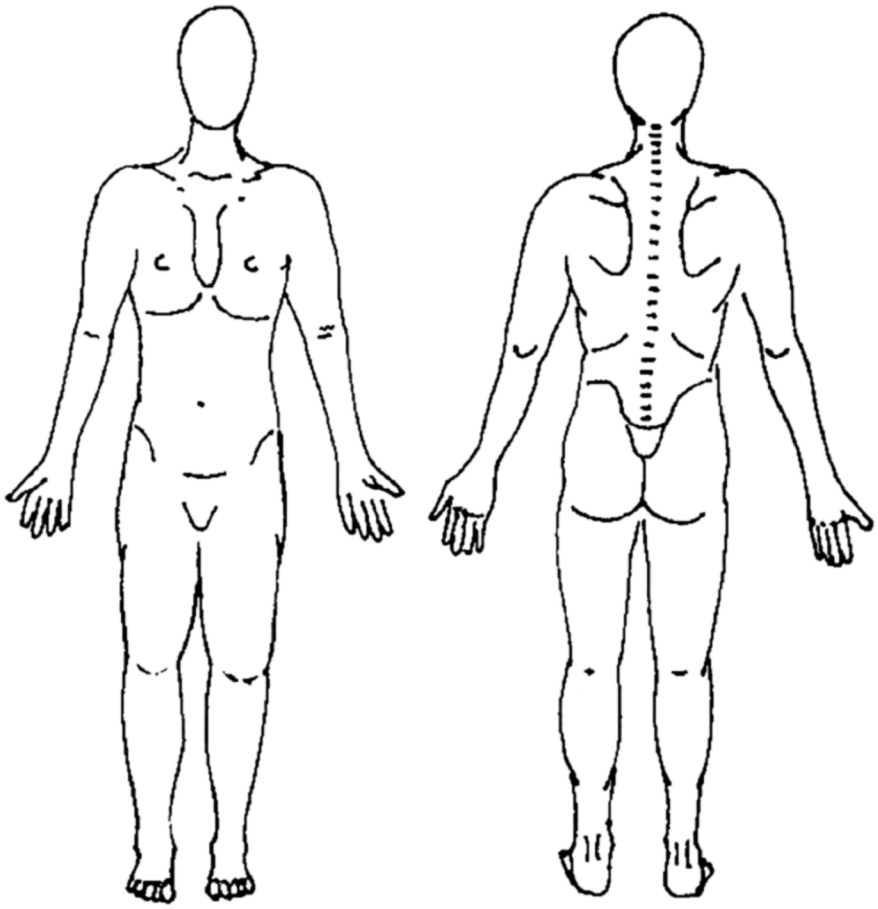
Reviewed By (staff signature):_____ Date:_____ Time:_____

Appendix 3. Pain Diagram and Pain Rating.*

Name: _____ Date: _____/_____/_____
mm dd yy

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. **Be VERY precise when drawing the location of your pain.** Use the key to indicate the type of symptoms.

Key: Pins and Needles = 000000 Stabbing = //////
Burning = xxxxxx Deep Ache = zzzzzz



Please rate your current level of pain on the following scale (check one):

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
(no pain)										(worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
(no pain)										(worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale (check one):

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
(no pain)										(worst imaginable pain)

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