Salem Health Rehabilitation Center

Problem Summary List MRN: _____

Salem Health® Hospitals & Clinics

TO ENSURE THAT YOU RECEIVE A COMPLETE AND THOROUGH EVALUATION, PLEASE PROVIDE US WITH THE IMPORTANT BACKGROUND INFORMATION ON THE FOLLOWING FORM. IF YOU DO NOT UNDERSTAND A QUESTION, YOUR THERAPIST WILL ASSIST YOU. THANK YOU!

PATIENT INFORMATION

First Name: _____ **Last Name:** _____ **Date of Birth:** _____

Age: _____ **Gender:** ☐ Male ☐ Female **What is your occupation?** _____

Are you currently working? ☐ Yes ☐ No **If you are not working, your last day of work was:** _____

Please list any job restrictions: _____

_____

Please list your leisure or recreational activities: _____

_____

Are you receiving home health care services? ☐ Yes ☐ No

Date of injury/accident/problem: _____

Date of surgery (if applicable): _____

Briefly describe the problem you are here for and how it started:

_____

_____

_____

Have you ever had this problem before? ☐ Yes ☐ No

What, if anything, makes your symptoms worse?

_____

_____

_____

What, if anything, relieves your symptoms?

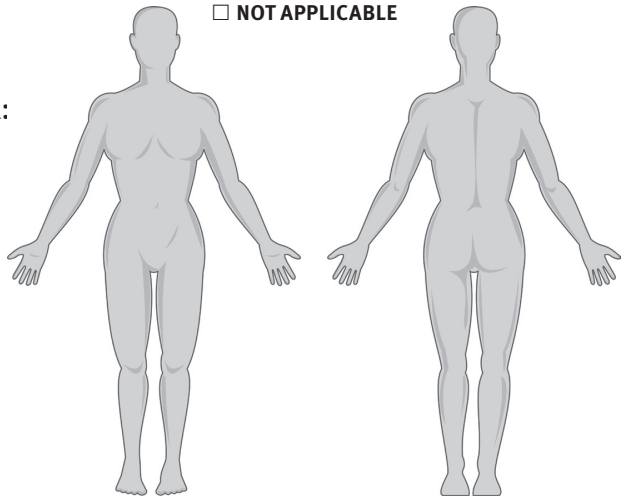
_____

_____

_____

PLEASE MARK THE LOCATION OF YOUR SYMPTOMS:

☐ NOT APPLICABLE



PLEASE INDICATE THE SEVERITY OF YOUR PAIN NOW, IF ANY: (CIRCLE NUMBER)

0 1 2 3 4 5 6 7 8 9 10

MILD MODERATE SEVERE

Have you had any of the following tests for this problem? (start with x-ray, then MRI)

☐ Bone scan ☐ CT scan ☐ MRI ☐ X-ray ☐ Ultrasound ☐ Other: _____

What are your goals for treatment? _____

PLEASE LIST ANY INJURIES, SURGERIES, OR OTHER CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED:

INJURY	SURGERY	HOSPITALIZED	REASON	APPROXIMATE DATES
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		

PLEASE CONTINUE ON THE REVERSE SIDE.

DSC 432884 (12/17)

Salem Health Rehabilitation Center

Problem Summary List

Salem Health® Hospitals & Clinics

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____

Have you ever been diagnosed/treated for any of the following conditions?

YOU

- ☐ Anemia
- ☐ Arthritis (rheumatoid, osteo, other)
- ☐ Asthma/emphysema/bronchitis
- ☐ Cancer (describe type): _____
- ☐ Depression
- ☐ Diabetes
- ☐ Drug or alcohol dependency
- ☐ Epilepsy/Seizures
- ☐ Fall(s) in the last 30 days
- ☐ Gastritis/ulcers
- ☐ Headaches
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Mental Health Services
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Pregnant (current)
- ☐ Recent bowel/bladder changes
- ☐ Recent weight gain/loss
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Other: _____

Please list known allergies:

- ☐ No known allergies
- ☐ Latex
- ☐ Tape/adhesive
- ☐ Skin allergies: _____
- ☐ Medications: _____
- ☐ Other: _____

Have you been treated by any of the following for this problem?

- ☐ Acupuncturist
- ☐ Chiropractor
- ☐ Dentist
- ☐ Emergency Room
- ☐ Massage therapist
- ☐ Medical doctor (MD)
- ☐ Naturopath
- ☐ Osteopath (DO)
- ☐ Physical/occupational therapist
- ☐ Psychiatrist /psychologist
- ☐ Other _____

If you have seen any of the above in the past three months for any reason (illness, medical condition, physical exam, etc.), please describe:

_____

_____

_____

_____

Are you a smoker? ☐ Yes ☐ No

If so, how many packs do smoke in an average day? _____

Do you regularly consume alcohol? ☐ Yes ☐ No

If so, how many drinks per day? _____ per week? _____

Primary Language Spoken: _____

Interpreter present? ☐ Yes ☐ No

_____
Patient Signature

_____
Date/Time

_____
Therapist's Signature

_____
Date/Time

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