REHAB SERVICES
SCHNECK MEDICAL CENTER

Thank you for completing this intake form. It will help us develop your plan of care.

Name:_____ DOB:_____
Best Phone Number to Contact you: _____

Referring Physician: _____
Next Appointment with referring Physician:_____
Primary Care Physician:_____

Please list, or supply a copy of, the medications you are currently taking:

_____
_____
_____

Have you had any recent: X-ray MRI Bone scan CT Scan
(Regarding this Diagnosis) Other_____

Do you have, or have you had, any of the following (circle):

Diabetes High blood pressure Cancer Pacemaker Stroke
Seizures Head injury Osteoporosis
Allergies:_____ Other_____

Please list any medical treatment related to current problem/diagnosis:

_____

Have you had any previous therapy? Yes or No
If so, explain: _____

I understand that is is my responsibilities as a patient to:

- Check with my insurance company for any prior authorization needed
- Let the therapist know if he/she needs to fill out insurance forms

I understand that:

- I may be responsible for any charges incurred for Rehab Services (wound care, physical, occupational, and/or speech therapy)
- After (3) no-show/cancellations, I will be discharged from Rehab Services and my physician will be notified."

_____ Date:_____
(patient/guardian signature)

Schneck Medical Center Rehab Services

Patient Self-Assessment

Primary Language: ( ) English Other: _____

Interpreter Required: ( ) Yes ( ) No

Communication Ability: ( ) Appropriate ( ) Impaired ( ) Unable

Speech Pattern: ( ) Clear ( ) Impaired Comments: _____

Follows Directions: ( ) Good ( ) Fair ( ) Poor

Able to Read: ( ) Yes ( ) No ( ) Limited

Able to Write: ( ) Yes ( ) No ( ) Limited

Learns best by: ( ) Doing ( ) Seeing ( ) Hearing ( ) Unable

Hearing Ability: ( ) Normal ( ) Hard of Hearing ( ) Uses hearing aid ( ) Deaf

Vision Ability: ( ) Normal ( ) Limited ( ) Blind

Visual Devices: ( ) None ( ) Glasses/Contacts

Emotional Status: ( ) Calm ( ) Agitated ( ) Anxious ( ) Other: _____

Cultural Barriers: ( ) None ( ) Other: _____

Support System: ( ) Spouse ( ) Caregiver ( ) Family ( ) Other: _____

Special Learning Needs: _____

Other Information: _____

Name: _____ Date: _____