Kessler
INSTITUTE FOR REHABILITATION
A Division of Select Medical

Outpatient Medical History/Screening Form

To be completed by the patient

Patient Name:_____ Spoken Language:_____

Emergency Contact:_____ Telephone # :_____

Family Physician/Internist:_____ Telephone # :_____

Religious/Cultural Needs: NO ☐ YES ☐ Please Explain:_____

Special Learning Needs: NO ☐ YES ☐ Please Explain:_____

Date of Injury:_____

Why are you here?_____

Medical Information:

	YES	NO		YES	NO
Hypertension (high blood pressure)	☐	☐	Alzheimers	☐	☐
Hypotension (low blood pressure)	☐	☐	Shortness of Breath	☐	☐
Pacemaker	☐	☐	Chest Pain /Angina /Heart Attack	☐	☐
Emphysema /Asthma	☐	☐	Urinary Urgency / Incontinence	☐	☐
Bleeding / Bruising (recent history)	☐	☐	Are You Pregnant?	☐	☐
History of diabetes	☐	☐	Have you had/have a Stroke	☐	☐
Hypoglycemia	☐	☐	Brain Injury	☐	☐
Cancer / Tumors / Growths	☐	☐	Multiple Sclerosis	☐	☐
Active seizure disorder	☐	☐	Spinal Cord Injury	☐	☐
Osteoporosis	☐	☐	History of pressure sores	☐	☐
Swelling Of Extremities	☐	☐	Other_____	☐	☐
Fractures	☐	☐	**Are you in pain?**	☐	☐
DATE:_____ AREA:_____	☐	☐	Location of pain_____		
DATE:_____ AREA:_____	☐	☐	_____		
Artificial Joints	☐	☐	**If you answered yes to any of the above:**		
Light-Headedness / Dizziness	☐	☐	Are you under the care of an	YES	NO
Anxiety / Panic Attacks (recent)	☐	☐	MD for these conditions?	☐	☐
Depression(recent)	☐	☐			

Allergies: _____

_____

Surgery(s) within last 3 months - Include Dates: _____

What are your treatment goals?:_____

If you need information regarding Advanced Directives, please contact the site Admission/Office Assistant. Advanced Directives are not honored in the Outpatient Setting.

FALL RISK ASSESSMENT*:	YES	NO
Have you fallen within the last year?	☐	☐
If so, how many times? _____		
Have any of these falls resulted in an injury within the last year?	☐	☐
Are you afraid of falling?	☐	☐
Have you recently felt unsteady on your feet or in your wheelchair?	☐	☐
Do you experience dizziness or vertigo?	☐	☐
Do you have vision problems that are not corrected by glasses?	☐	☐
Do you use sedatives that affect your level of alertness during the day?	☐	☐
Do you have memory / cognitive difficulties?	☐	☐
Do you have a lower extremity disability that affects walking?	☐	☐

AS PER CMS FALL SCREENING CRITERIA

***Patient is considered a fall risk if patient has fallen two or more times in the past year**

***Patient is considered a fall risk if patient has fallen one time with resulting injury in the past year**

NUTRITIONAL SCREENING	YES	NO
Unexplained weight loss? (>5% in last 30 days)	☐	☐
Recent loss of appetite/aversion to food?	☐	☐
Do you have difficulty swallowing?	☐	☐
Decrease in food intake?(<50% for 3 days or more)	☐	☐
Are you under the care of a MD for these conditions?	☐	☐

CURRENT MEDICATION: (List below)

Are all meds prescribed by a physician? Yes ☐ No ☐

*_**FALL RISK**_ - *Patient is considered a* fall risk *if they answer yes to three or more fall risk assessment questions, if they meet CMS screening criteria for fall risk, or if therapist judgment indicates. Clinician should refer to the Fall Prevention Policy in the OP KRC P&P manual.*

PATIENT SIGNATURE:_____**DATE:**_____**Time:** _____

Relationship if other than patient / parent / guardian if minor:_____

This information will be used as a guide to your treatment plan.
If you need any medical follow-up, please contact your physician

To be completed by evaluating Therapist

Patient has been identified as a fall risk : yes ☐ no ☐

If yes, fall prevention program has been implemented: yes ☐ no ☐

Patient has been identified as a nutrition risk : yes ☐ no ☐ (If yes, notify MD)

Patient would benefit from a speech pathology referral for swallowing: yes ☐ no ☐ (If yes, notify MD)

Patient would benefit from a Social Services referral: yes ☐ no ☐ (yes if therapist feels patient life is threatened, or if patient is a threat to others)

Therapist Signature: **Date:** **Time:**

Therapist Signature: **Date:** **Time:**

Therapist Signature: **Date:** **Time:**

Therapist Signature: **Date:** **Time:**

(Therapist has reviewed medical history form with patient)