



**OUTPATIENT INFORMATION
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Therapy Attending:

- Physical Therapy
- Speech Therapy
- Occupational Therapy

Name: _____ Age: _____

Occupation (if retired, prior occupation): _____

Reason for attending therapy: _____

Onset of injury/disorder: _____

Medical History (Including any surgeries and medical conditions): _____

Previous/Current Therapies: _____

Allergies (foods and/or medications): _____

- Yes No Are you allergic to bananas, avocados and/or chestnuts
- Yes No Have you ever had a reaction to any of the following:
Band-aids, rubber balls, balloons, condoms and/or gloves
- Yes No Are you allergic to latex?

Yes No Don't Know Have you ever been treated for MRSA. If, yes, when? _____

Yes No Do you currently have an open wound

Current Medications (Please list all): _____

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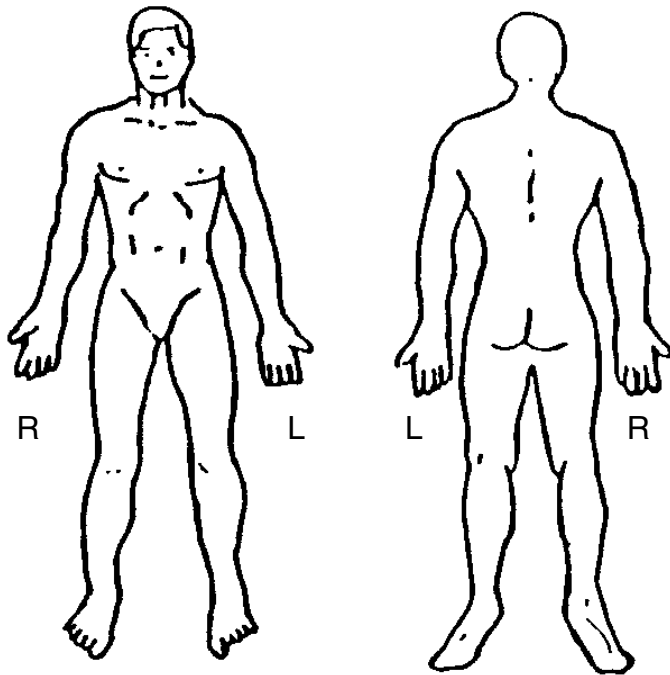
Living Situation:

- Private home/apartment Other: _____
 Assisted living facility

Lives:

- with family members/friend Number of residents in home: _____
 with personal care assistant
 Lives alone
 Temporary living arrangement: _____
 Other: _____

Pain Assessment:



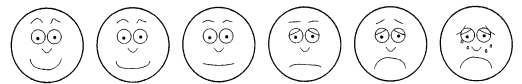
Please indicate location of
numbness or pain:

- X = PAIN
O = NUMBNESS

Description of pain: _____

Circle level of pain:

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10



0 - No pain

10 - Intense pain

At present time would you say your health is:

- excellent very good good fair poor

Date: _____ Time: _____ Patient Signature: _____

Form Completed by: _____