Cooperman Barnabas Medical Center | RWJBarnabas HEALTH

Name: _____

Date of Birth: _____

Date: _____

SUMMARY LIST

Outpatient Rehabilitation Services

Preferred Name: _____

Gender you identify with: ☐ F ☐ M ☐ Transgender M → F ☐ Transgender F → M ☐ other _____

Initial Visit Date: _____ Referring MD: _____ Primary MD: _____

Patient Problem (chief complaints): _____

Allergies/Adverse Allergic Drug Reactions (Note symptoms exhibited): _____

_____ ☐ No Allergies

Please check all significant medical diagnoses and conditions: ☐ No significant medical history

Diagnosis/Condition	Date	Diagnosis/Condition	Date
☐ Cancer **Type:**		☐ Multiple Sclerosis	
☐ Diabetes		☐ Seizures	
☐ High Blood Pressure		☐ Infectious disease (TB / Hepatitis / MRSA)	
☐ Heart Disease		☐ Skin conditions	
☐ Angina/Chest Pain		☐ Polio / post polio	
☐ Deep Vein Thrombosis		☐ Urinary incontinence	
☐ Pacemaker		☐ Depression	
☐ Stroke		☐ Sleep disorder	
☐ Circulation Problems		☐ HIV positive	
☐ Arthritis		☐ Are you / could you be pregnant	Yes / No
☐ Osteoporosis / Ostopenia		☐ Other	
☐ Lung problems		☐ Other	
☐ Asthma		☐ Other	

Please list all significant surgical/invasive procedures:

	Date

Current medications should include prescribed and over the counter medications, herbal medications and supplements

☐ No medications at this time _____ / _____ / _____

MEDICATION/VITAMINS/SUPPLEMENTS	DOSE	FREQUENCY	ROUTE

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COMPREHENSIVE OUTPATIENT REHABILITATION CENTER
CANCELLATION / NO SHOW POLICY

Research has demonstrated that for rehabilitation therapy to be effect and efficient, it is essential to have patients compliant with their scheduled plan of care. Those patients who are compliant with their schedule and home exercise program achieve their functional goals more efficiently. Due to the high volume and our expanding waiting list for patients, CBMC is adjusting the cancellation policy.

- **If you are more than 15 minutes late, we may need to reschedule your appointment.** Therapy sessions range from 30 to 60 minutes, depending on your treatment plan. It is important to your progress that you arrive on time so that we may provide you with the most efficient and effective quality care.

- **If you need to cancel or reschedule an appointment, please call us at (973) 322-6333, option 1, with at least 24 hours' notice.** If you have transportation issues and or concerns, please let your therapist know, so that a realistic care plan can be established.

- **If you cancel with less than 24 hours' notice on 2 occasions, do not show for 2 appointments, or miss more than 50% of your visits, we reserve the right to cancel future appointments.**

We are committed to your care, and your progress is dependent on consistency and continuity of care. Your safety is important to us. Any weather related cancellations would not be subject to this cancellation policy.

Thank you for choosing RWJBarnabas Health for your care.

Jennifer Lau, PT, MPT, MSCS Physical Therapist
Director of Outpatient Rehabilitation

Date: _____

_____

Patient Signature

Cooperman Barnabas Medical Center | RWJBarnabas HEALTH

Name _____

DOB _____

Date _____

SPEECH LANGUAGE INTAKE FORM

Have you received any previous evaluations or therapy for your current concerns? ☐ yes ☐ no

If "yes" for what reason and where _____

_____

Are you currently receiving any other therapy? ☐ yes ☐ no

If "yes" for what therapy and for what reason _____

_____

Chief Complaint (Language): I am experiencing difficulty with: **please check all that apply**

☐ Receptive language skills ☐ Expressive language skills ☐ Word finding/thought organization

☐ Writing ☐ Reading ☐ None

Chief Complaint (Speech): I am experiencing difficulty with: **please check all that apply**

☐ Fluency/Stuttering ☐ Articulation/Pronunciation ☐ Coordination/Motor planning ☐ None

Chief Complaint (Cognitive): I am experiencing difficulty with: **please check all that apply**

☐ Memory ☐ Attention ☐ Processing Skills ☐ Problem Solving ☐ Safety Judgments ☐ Organization ☐ None

I am experiencing difficulty in the following settings: **please check all that apply**

☐ School ☐ Engaging with family/friends ☐ Work ☐ Driving ☐ Hobbies/Interest

How are your current deficits affecting you in social environments? _____

_____

_____

Do you experience any difficulty with swallowing? ☐ Yes ☐ No

Occupational History: ☐ Employed (specify occupation) _____

☐ Retired _____ ☐ Unemployed _____

Highest Level of Education: ☐ Current Grade level _____ ☐ High School Diploma ☐ College Degree

☐ Masters Degree ☐ Other _____ Focus of study _____

Family History:

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partnership

Spouse's Name _____ Children's Name(s) _____

Patient Residence:

Who do you reside with? _____

Social History:

Do you drink alcoholic beverages? ☐ yes ☐ no If "yes" how frequently? _____

Do you smoke? ☐ yes ☐ no If "yes" how frequently? _____

Hobbies/Interests _____

What goals would you like to achieve in therapy? _____

_____