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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Date: ______________________

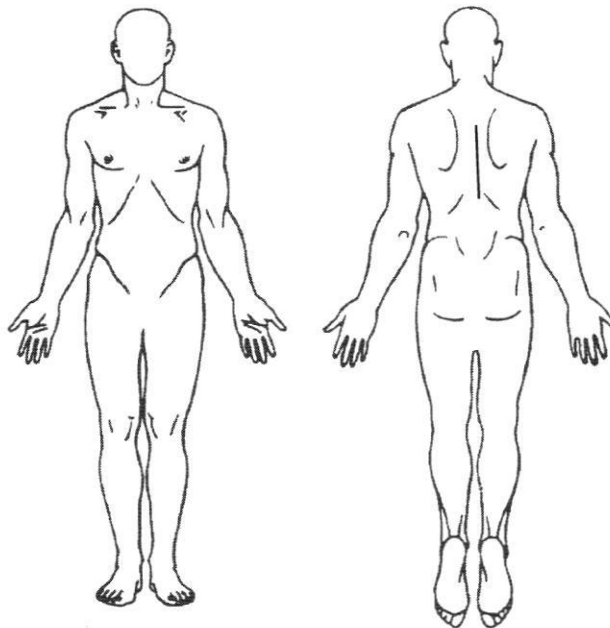
Symptoms Questionnaire

Rate your symptoms on the scale below:

0	1	2	3	4	5	6	7	8	9	10

no symptoms moderate intense

Indicate the location of your symptoms on the diagram below:



Describe your symptoms: (dull / sharp / burning / stabbing / numbness / pins & needles / other__________________)

(constant / intermittent / occasional)

When did your symptoms begin? ______________________________

What makes your symptoms worse? ______________________________

What makes your symptoms better? ______________________________

Do your symptoms wake you at night? (yes / no)

Have you received therapy for this condition before? (yes / no) (PT / OT / lymphedema)

When? ____________________

Have you received any other treatment for this condition? (yes / no)

Please indicate what type and when: ____________________

What is your occupation? ____________________

Do you participate in any sports or recreational activities (ie: walking, swimming, yoga)?

Please describe type and how often: ____________________

What is your goal for treatment? ______________________________