Name: ______________________________ **Date:** ______________

Birth Date: ______________ **Height:** ______________ **Weight:** ______________

Significant Medical Diagnoses & Conditions: **(Please check all that apply)**

___ Heart Disease	___ Diabetes	___ High Blood Pressure	___ Pacemaker
___ Cancer	___ Tuberculosis	___ Visual/Hearing Impaired	___ Epilepsy
___ HIV/AIDS	___ Arthritis	___ Fever	___ Fibromyalgia
___ Stroke	___ Asthma	___ Latex Allergy	___ Scoliosis
___ Osteoporosis	___ Hepatitis	___ Pregnant	___ Pneumonia
___ Swallowing Problems	___ Rash / Wound	___ Vomit / Diarrhea	___ Mental Health

Therapist's comments: ______________________________

Please list any medications you are taking (include prescriptions, over the counter drugs & herbals): ______________

____

Any adverse reactions to medications? Y N If yes, please describe: ______________

List any allergies to medications: ______________________________

Where is your pain or problem located: ______________ What are your current symptoms: ______________

List any diagnostic tests you have had for this condition: ______________

Any significant surgery/procedures for your condition? Y N Type: ______________

Any injections for your condition? Y N Date: ______________

Please rate your pain using a 0 – 10 scale (0 = no pain, 10 = the worst pain you can imagine)

Worst pain since onset: ______ Least pain since onset: ______ Today's pain: ______

Is your pain: __ Constant __ Intermittent What makes your pain / problem better? __________ Worse? __________

When did the injury or problem occur?

First episode: ______________ Second episode: ______________ Third episode: ______________

How did the injury or problem occur? ______________________________

What was your prior level of function? ______________________________

Is there pain present at night? Y N What position helps you to sleep? ______________

Are you a victim of abuse or neglect? Y N

Employment History:

Are you currently working? ______________ If no, how many total days of work have you missed? ______________

Are your work duties? Full Restricted How many hours per week do you work? ______________

What type of work do you do & where do you work? ______________________________

What do you hope to accomplish with therapy/ what are your therapy goals?

____

When are you scheduled to see your doctor again? ______________

To the best of my knowledge and belief, the information I have given is complete and true.
I hereby give my consent to receive Therapy services at Palomar Health.

Patient Signature: ______________________________

Therapist Signature: ______________________________ **Date:** ______________ **Time:** ______________

Pt Name
MR #
Date ___________ Age _____
Sex: ☐ M ☐ F
Affix pt name label here

N7770-016 (1/18/13)

SUBJECTIVE INTAKE FORM
REHAB SERVICES

PALOMAR HEALTH
A California Public Healthcare District

LATEX SCREENING TOOL

1. Do you have any allergy to latex products? .... ☐ Yes ☐ No

2. Do you have any allergies to the following foods? .... ☐ Yes ☐ No

   If "yes" check all that apply:

☐ **AVOCADOS**	☐ POTATOES
☐ **BANANAS**	☐ PEACHES
☐ **CHESTNUTS**	☐ PAPAYA
☐ KIWIS	☐ TOMATOES

3. Have you ever reacted after handling or using balloons? .... ☐ Yes ☐ No

4. Have you ever reacted after handling/using clothing with elastic or spandex? ... ☐ Yes ☐ No

ANY "YES" ANSWER REQUIRES COMPLETION OF "LATEX ALLERGY QUESTIONNAIRE"

____ Healthcare Worker

________________________ Date

Pt Name
MR #
Date ___________ Age ____
Sex: ☐ M ☐ F
Affix pt name label here

8720-9001PPH (03/15/04)

LATEX SCREENING TOOL

PALOMAR HEALTH

A California Public Healthcare District

PALOMAR
HEALTH

FALL PREVENTION CHECKLIST

YES__ NO__ 1) Have you fallen before or been injured in a fall?
If Yes; When was your most recent fall?______

YES__ NO__ 2) Do you feel weaker than normal in your legs?

YES__ NO__ 3) Have you experienced increased frequency of dropping items?

YES__ NO__ 4) Do you have difficulty lifting or carrying groceries?

YES__ NO__ 5) Have you stopped doing daily activities or exercise due to fear of falling?

YES__ NO__ 6) Do you experience incontinence?

YES__ NO__ 7) Do you feel dizzy or lightheaded when you stand?

YES__ NO__ 8) Has your eyesight diminished recently?

YES__ NO__ 9) Have you experienced hearing loss?

YES__ NO__ 10) Do you have foot pain when walking, due to bunions, ulcers, callouses, or hammer toes?

YES__ NO__ 11) Do you feel unsteady on your feet or shuffle when walking?

YES__ NO__ 12) Do you need to use a walker or cane when you walk?

Patient Name: ____

Date: __________

PLACE STICKER HERE