

## PATIENT INFORMATION SHEET

Please fill out as accurately as possible NAME: \_\_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ DAYTIME PHONE: \_\_\_\_\_ EVENING PHONE: \_\_\_\_ FAMILY/REFERRING PHYSICIAN: DATE PROBLEM BEGAN: BRIEFLY DESCRIBE THE PROBLEM: HAVE YOU ALREADY HAD TREATMENT FOR THIS PROBLEM? YES / NO IF YES, PLEASE BRIEFLY DESCRIBE THE TREATMENT: \_\_\_\_\_ I HAVE OR HAVE HAD: FOR AQUATIC THERAPY ONLY: YES NO YES NO DIABETES DO YOU HAVE A POOL? DO YOU HAVE A CHLORINE ALLERGY? A PACEMAKER HIGH BLOOD PRESSURE DO YOU HAVE A FEAR OF WATER? SEIZURES/CONVULSIONS DO YOU HAVE ANY OPEN WOUNDS? RHEUMATOID ARTHRITIS METAL IMPLANTS TO BE FILLED OUT BY THERAPIST ONLY: **HEART PROBLEMS** CONCERNS IDENTIFIED: WEIGHT? YES NO CANCER OTHER CONCERNS: \_\_\_\_ OSTEOPOROSIS WEIGHT LOSS/GAIN > 10 LBS.  $\square$ THERAPIST SIGNATURE DATE

DATE

PATIENT SIGNATURE

**INSTRUCTIONS:** This log applies to patients receiving ambulatory services in the same setting for 3 or more visits. This is to be maintained and updated at each visit as necessary to provide current patient information. This log must be placed in the very front of the medical record. "Significant" means major illness, conditions or procedures which may be important to or influence on care decisions.

| PATIENT:                    | Date of Birth:            |
|-----------------------------|---------------------------|
| Family/Referring Physician: | Account/Medical Record #: |

| ALLER          | RGIES/DRUG REACTIONS                         | DATE | CURRENT MEDICATIONS  Routinely taken prescription and non-prescription. | Discharge "X" |
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| Interview Date | SIGNIFICANT<br>Diagnosis/Conditions          | Date |   |               |
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| Interview Date | SIGNIFICANT<br>Operative/Invasive Procedures | Date |   |               |
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AMBULATORY CARE SUMMARY LOG (OUT PATIENT REHABILITATION CENTER) NCH HEALTHCARE SYSTEM, NAPLES, FL



NCH #0000 Orig: Unknown Rev: 6/04