Southern New Hampshire Medical Center
REHABILITATION SERVICES

Patient Information Summary Form

Please complete the following health survey. The information you provide will help us in determining the best course of therapy for you. If you have any question on any of the questions asked, please discuss them with your therapist. Thank you.

About You

Name: _____Date of birth: ____/____/____
Sex: ❑ Male ❑ Female Are you ❑ right-handed ❑ left-handed ❑ ambidextrous Primary language: _____
Do you have any cultural or religious beliefs that would affect your care? If yes, please explain: _____
Occupation: _____
❑ Currently working outside the home full-time/ part-time ❑ Student ❑ Retired
❑ Not currently working due to current condition ❑ Unemployed ❑ Disabled

Living / Residential Arrangement

Living Arrangement: ❑ Alone ❑ With spouse/significant other ❑ With children ❑ With parent or guardian ❑ Other: _____
Living Environment: ❑ Stairs, no railing ❑ Stairs, railing ❑ Ramps ❑ Other: _____

General Health

How would you rate your health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor
What is your current Height:_____ Weight:_____
Do you wear? ❑ Glasses ❑ Contact lenses ❑ Hearing aid ❑ Cochlear Implant
Are you pregnant or trying to get pregnant? ❑ Yes ❑ No
Have you experienced a change in your bowel or bladder patterns ❑ Incontinence ❑ Constipation
Have you fallen in the last six months? ❑ Yes ❑ No

Health Habits

Medications
Do you take prescription medications? ❑ Yes ❑ No
Please list:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Do you take any non-prescription medications? ❑ Pain /Anti-inflammatory, Please list_____
❑ Herbal Supplements ❑ Laxatives ❑ Antacids ❑ Decongestants ❑ Antihistamines
❑ Other:_____

Do you have allergies (medicines, chlorine, bromine, bees, latex, adhesives, food, other)? ❑ **Yes** ❑ **No**
If yes, explain: _____
Surgical History
Please list any surgeries dates
1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

AD0031

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Please check any of the following conditions that you currently being treated for or have been treated in the past for.

❑ Anemia	❑ Headaches/migraines	❑ Pacemaker
❑ Arthritis	❑ Heart Disease	❑ Psoriasis
❑ Bleeding Tendency	❑ Hepatitis A, B, C	❑ Respiratory Problems
❑ Cancer /_____	❑ High Cholesterol	❑ Stomach/Bleeding Ulcer
❑ Diabetes	❑ High/Low Blood Pressure	❑ Stroke
❑ Dizziness/Fainting	❑ Joint Disease	❑ Thyroid Disease
❑ Epilepsy/Seizures	❑ Metal or Other Implants	❑ Tuberculosis
❑ Fibromyalgia	❑ Open Wounds	❑ Tumor/Cyst
❑ Glaucoma	❑ Osteoporosis/Osteopenia	❑ Kidney Disease
❑ Depression	❑ Are you taking medication for anxiety?	

Other: _____

Therapy Expectations

What are your goals for therapy? _____

Have you received physical, occupational or speech therapy in the past? ❑ Yes ❑ No

If so, when / for what reason?_____

Please Sign Here

To the best of my knowledge, this information I have provided is accurate and complete.

_____ _____ _____

Patient's Signature Date Therapist's Signature

Therapist's Plan Reason/Diagnosis:_____ Frequency:_____ Duration:_____

Updates:

Updates:

AD0031

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Attendance Policy

Thank you for choosing Southern New Hampshire Medical Center Rehabilitation Services.
We look forward to working with you.

As a partner in your care, our goal is to help you meet your rehabilitation needs through a series of scheduled visits. Our attendance policy will help you understand the time needed to regain function and help you reach your goals. We ask you to agree to the following:

- Please arrive on time and check in with the receptionist. Arriving after your scheduled appointment can limit your treatment time and the treatment time of other patients.
  (If you are more than 10 minutes late, you may be asked to reschedule.)

- Kindly give at least 24 hours notice if you need to reschedule or cancel an appointment.
  (Please know that cancelled appointments may delay your recovery.)

    - Two or more missed/cancelled appointments within a month shows that you are not, currently, fully engaged in your recovery and may result in your discharge until you are able to continue with therapy. If necessary, we will notify your referring provider and encourage you to speak with him or her as well. ***(We understand unusual circumstances arise, and we will accommodate them if possible.)***

At Southern New Hampshire Medical Center Rehabilitation Services we are committed to being on time for your appointments. However, on occasion, we may run behind schedule. We thank you in advance for your understanding and patience.

We are dedicated to your recovery and strive to provide you with a higher level of care. Please sign and date below to indicate your understanding of our attendance policy. Thank you.

_____ Date: _____
Patient Signature

_____ Date: _____
Therapist Signature