WEST HOUSTON MEDICAL CENTER
COMPREHENSIVE OUTPATIENT
REHABILITATION SERVICES

SUMMARY LIST

Name: ________________________________ Date: ______________________________

Form completed by: ____

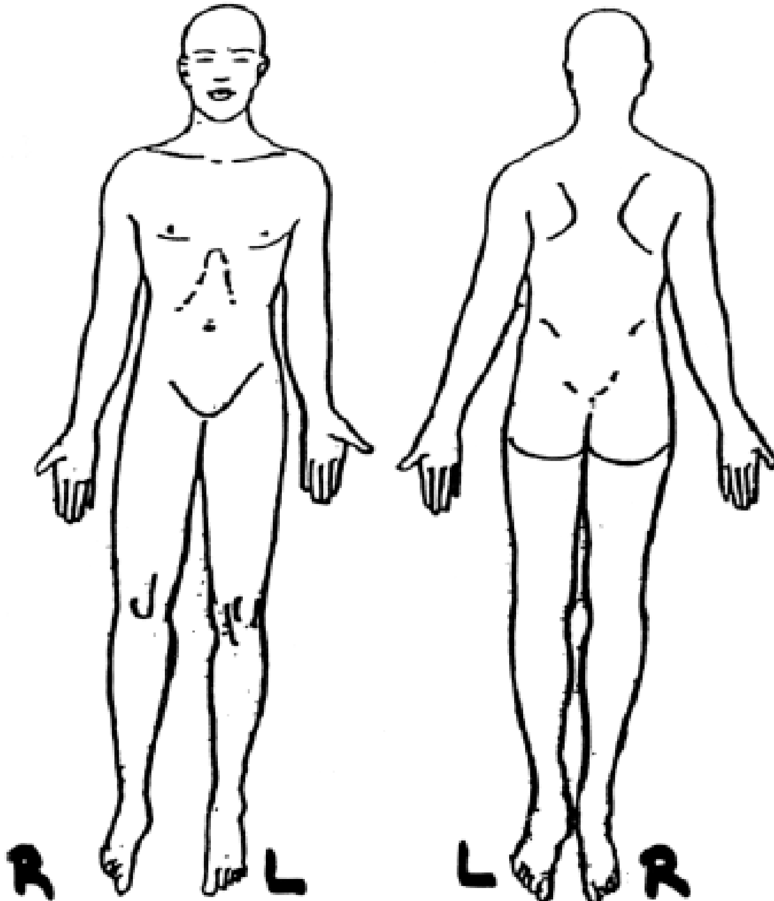
Age: ________ Referring Physician: ____

What is your reason for visiting our clinic? (Chief Complaints)_________________________

____

____

Please mark the areas you feel pain on the drawings. Put an "E" if it is external or an "I" if it is internal next to the areas that you have pain. (Put an "EI" if the pain is both internal and external)



We have listed some words below to help you describe your present pain. Please circle all that apply to you.

Aching	Exhausting	Numb	Stinging
Agonizing	Freezing	Piercing	Suffocating
Annoying	Frightful	Pinching	Tender
Burning	Grueling	Pricking	Terrifying
Cold	Heavy	Pulling	Tight
Cool	Hot	Punishing	Tingling
Cramping	Miserable	Radiating	Tiring
Cruel	Nagging	Sore	Torturing
Dreadful	Nauseous	Stabbing	Tugging

Which words would you use to describe the pattern of your pain?

Continuous	Rhythmic	Brief
Steady	Periodic	Momentary
Constant	Intermittent	Transient

Rate your pain on a scale of 0-10 (0= No Pain at all and 10 = Extreme Pain)

0 1 2 3 4 5 6 7 8 9 10

When did the pain begin?____

What causes the pain?____

What makes the pain worse?____

What makes the pain better?____

Does the pain interfere with your ability to sleep at night?______________________

How many hours do you sleep at night?__________________________________

Please list any previous injuries:

____________________ ____

Date Description

____________________ ____

Date Description

Do you have any of the following symptoms at this time? (Check if yes)

☐ Unintentional weight loss or weight gain of 10 pounds in the last 3 months?

☐ Nutritional intake less than 50% of your usual over the last 2 weeks?

TB Exposure Screening/TB Other Infectious Disease Questionnaire

Circle (Y) or (N)

Have you or any close contacts traveled to Asia in the last 2 weeks? (Y) (N)	Loss of appetite? (Y) (N)
Did you have contact with poultry while in Asia? (Y) (N)	Do you have close contacts who have been told they have pneumonia? (Y) (N)
Do you work in a hospital or in healthcare? (Y) (N)	Swollen glands, (usually in the neck)? (Y) (N)
Productive cough for 3 weeks or longer? (Y) (N)	Recurrent infections? (Y) (N)
Persistent weight loss without dieting? (Y) (N)	Coughing up blood? (Y) (N)
Persistent low grade fever? (Y) (N)	Shortness of breath? (Y) (N)
Night sweats? (Y) (N)	Chest Pain? (Y) (N)

Patient ____

What health care or services have you received since your initial injury/surgery/or hospital discharge?

☐ Home Health Agency ____

☐ Care by family/self. What? ______________________________________

☐ Inpatient Rehab Center, Where? _______________________________

☐ Outpatient Rehab Center, Where? _______________________________

What types of treatments have you had for this injury/injuries and with whom?

Physician	Specialty	Treatment
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

HOSPITALIZATION
AND SURGICAL HISTORY

_____________ ____
Date Explanation

_____________ ____
Date Explanation

_____________ ____
Date Explanation

_____________ ____
Date Explanation

ALLERGIES: ☐ No ☐ Yes; If Yes, Please complete section below:
List all drug, food, latex allergies and type of reaction experienced with each.

____

____

SOCIAL HISTORY ____

Do you live alone?
Who do you depend on for your support? (assistance) ______________________________
Is there anything else you want to discuss about your home environment? _______________
____

Do you currently feel unsafe in your home? ☐ Yes ☐ No

Are you still working? ☐ Yes ☐ No
What type of work? ____
Part-time/Fulltime? ____
Full/Light Duty? ____

Do you exercise on a regular basis? ☐ Yes ☐ No
Explain ____

Patient _________________________________

MEDICATION HISTORY (please include prescription and over-the-counter medications)

Current Medications	**Dosage**	**Date Medication Started**	**Prescribing Doctor**

DIETARY SUPPLEMENTS - Please list any dietary supplements you are currently taking (vitamins, weight loss, **herbals**).

Patient ___________________________________

FALLS: Have you fallen in the last year? **No** ☐ **Yes** ☐
If Yes, how many times?_____________ please explain:
____

____

Are you fearful of falling? ☐ **Yes** ☐ **No**

Do you find yourself reaching out with your hands to grasp onto things when moving about?
☐ **Yes** ☐ **No**

Is it difficult for you to walk around your house in the dark? ☐ **Yes** ☐ **No**

Do you have an **out of Hospital DNR** (**Do not resuscitate**)? ☐ **Yes** ☐ **No**

If **Yes**, please provide a copy for chart or understand **out of Hospital DNR** will not be honored.

MEDICAL HISTORY – Please **X** all that apply to your personal medical history.

☐ Allergies/Hay fever________________
☐ Anemia ___________________________
☐ Anxiety/Depression ________________
☐ Arrhythmia _______________________
☐ Arthritis____________________________
☐ Asthma ____________________________
☐ Cancer ____________________________
☐ Chest Pain/Angina _________________
☐ Congenital Heart Disease ____________
☐ Congestive Heart Failure ____
☐ COPD _____________________________
☐ Diabetes____________________________
☐ Dizziness/Fainting _________________
☐ Seizure Disorder/Epilepsy___________
☐ Fatigue_____________________________
☐ GI Disorder ________________________
☐ Glaucoma___________________________
☐ Gout_______________________________
☐ Headache __________________________
☐ Head Injury ______________________
☐ Heart Attack _____________________
☐ Heart Murmur ____________________
☐ Heart Palpitations__________________
☐ High Cholesterol _________________
☐ Hypertension (High Blood Pressure)
☐ Liver Disease _____________________
☐ Loss of Bowel Bladder Control _____
☐ Menstrual Dysfunction ____________
☐ Osteoporosis _____________________
☐ Rheumatic Fever_________________
☐ Sexual Dysfunction _______________
☐ Shortness of Breath_______________
☐ Smoking/Tobacco Usage
☐ Stroke/TIA/s
☐ Thyroid (Endocrine) Disease _______
☐ Ulcer _________________
☐ Other (Specify) _________________

Women Only: **Pregnant?** ☐ **Yes** ☐ **No** **Nursing?** ☐ **Yes** ☐ **No**

Patient ______________________________________

Revised 7/5/09