Idaho State University

ISU Physical & Occupational Therapy Associates
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Adult Patient Profile

Patient Name: _____ **DOB:** _____

Person Completing Form: _____ **Age:** _____

Emergency Contact: _____ **Phone No.:** _____

Address: _____ **City & Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email:** _____

Is it ok for us to leave a message regarding your treatment at the following #s?

Home: ☐ Yes ☐ No **Cell:** ☐ Yes ☐ No **Work:** ☐ Yes ☐ No

Reasons for Rehabilitation

Diagnosis/Conditions/Reasons you are seeking rehabilitation services: _____

_____

_____

Your Primary goal for therapy is to be able to? _____

_____

_____

Things you would like to do at home that you cannot do right now (e.g., talking on the phone, daily activities, hobbies, etc.)

_____

_____

Activities you would like to do in the community that you cannot do right now (e.g., public speaking, going out to eat, ect.)

_____

_____

Health History

Does you have (or have you had) any of the following conditions? Please check all that apply.

Heart Disease	☐ Y ☐ N	Thyroid Disorder	☐ Y ☐ N	Bowel Issues	☐ Y ☐ N
Stroke	☐ Y ☐ N	Kidney Disease	☐ Y ☐ N	Seizures	☐ Y ☐ N
High Blood Pressure	☐ Y ☐ N	Diabetes	☐ Y ☐ N	Bleeding Disorder	☐ Y ☐ N
Lung Disease	☐ Y ☐ N	Arthritis	☐ Y ☐ N	Asthma/Hay Fever	☐ Y ☐ N
Cancer	☐ Y ☐ N	Headaches/Migraines	☐ Y ☐ N	Swallowing Issues	☐ Y ☐ N
Head Injury	☐ Y ☐ N	Concussion	☐ Y ☐ N	Other:_____	☐ Y ☐ N

Are you or could you be pregnant? ☐ Yes ☐ No

How would you describe your general health? ☐ Good ☐ Fair ☐ Poor If fair/poor, please explain:

_____

_____

Have you recently been or have you ever been hospitalized related to the condition for which you are seeking treatment? ☐ Yes ☐ No If yes, please provide the following information:

When: _____ **Where:** _____

How Long (Admit/Discharge Dates): _____

Have you experienced significant weight change (loss or gain) in the past 6 months?

☐ Loss ☐ Gain ☐ No Change If yes, how many pounds? _____

Was the change in weight intentional or expected? ☐ N/A ☐ Yes ☐ No

List any dietary restrictions (diabetic, food allergies, etc.): _____

_____

Are there any other health problems that you would like us to know about? ☐ Yes ☐ No

If yes, please explain: _____

_____

Do you use a wheelchair, walker, or other assistive device for mobility? ☐ Yes ☐ No

If yes, identify which type of device: _____

Do you have any balance problems? ☐ Yes ☐ No

Do you have left or right sided weakness? ☐ Yes ☐ No If yes, which side: _____

Have you had any previous surgeries? ☐ Yes ☐ No If yes, please explain below.

	Surgery/Procedure	Month/Year
1.		
2.		
3.		
4.		

Does you have any allergies? ☐ Yes ☐ No If yes, please list any allergies and the reaction you experience to each below (e.g., allergies to medications, latex, foods, products, etc.)

	Allergen	Reaction
1.		
2.		
3.		
4.		
5.		

Medications:

Are you currently taking any medication? ☐ Yes ☐ No If yes, please list below.

1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Previous Therapies:

Type of Therapy	Dates	Agency	Name of Therapist
Speech Therapy			
Physical Therapy			
Occupational Therapy			
Psychological/Counseling			
Other Rehab			

Special Needs: (Please check all that apply)

Vision: ☐ No Problems ☐ Glasses/Contact Lenses ☐ Visual Difficulties ☐ Glasses for Reading ☐ Require Enlarged Print

Communication: ☐ No Problems ☐ Difficulty Reading ☐ Difficulty Writing

☐ Communication Needs/Devices/Assist, please specify: _____

_____

Hearing: ☐ No Problems ☐ Hearing Aid(s) ☐ Difficulty Hearing

Living Situational/Level of Independence:

Home Type: ☐ Mobile/Trailer ☐ Single Level ☐ Split Level ☐ Multi Story ☐ Apt./Condo/Townhouse

☐ Other: _____ # of Steps to Main Living Space: _____

Live With: ☐ Spouse or Significant Other ☐ Grown Children ☐ Friend(s) ☐ Alone ☐ Caregiver

☐ Assisted Living ☐ Long-Term Care Facility ☐ Other: _____

Independence: Please rate your ability to perform the activities below, using the letters I = Independent A = Assistance

Bathing/Grooming _____ Dressing _____ Household Chores _____ Stairs _____ Driving _____

Education/Work History:

☐ _____ Grade ☐ High School Diploma ☐ Assoc. Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Post Graduate

I learn best by: ☐ Discussion ☐ Demonstration ☐ Written Language ☐ Videos ☐ Other: _____

Is there any information or education that you would like your therapist to provide to you? ☐ Yes ☐ No

If yes, please explain: _____

Work Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Medical Leave ☐ Retired

Occupation: _____ **Do you have any vocational concerns?** ☐ Yes ☐ No

Psychosocial History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Children (how many): _____ **Ages:** _____

Is there anything in your home environment that causes concern(s) for your safety or for other family members?

☐ Yes ☐ No If yes, please explain: _____

Do you have any special cultural, religious, or spiritual practices that you would like us to recognize/address while here?

☐ Yes ☐ No If yes, please explain: _____

Are you experiencing any of the following: ☐ Loss of interest in previously enjoyed activities ☐ Feelings of Hopelessness

Below are words to describe your personality and behavior. Circle all that apply and underline all that you had before your accident/stroke/diagnosis.

Happy	Aggressive	Depressed	Enthusiastic	Friendly
Warm	Independent	Energetic	Distractible	Jealous
Tense	Prefers to be Alone	Dependent	Affectionate	Relaxed
Critical	Easily Fatigued/Tired	Directive	Can't Sleep	Impatient
Shy	Vigorous	Calm	Irritated	Angry

List description(s) not listed above: _____

Personal Interests/Activities:

What are your favorite leisure activities/hobbies? _____

What are your favorite TV shows? _____

What magazines/books/newspapers do you read? _____

Do you like to talk on the phone? ☐ Yes ☐ No

Do you use the internet/email? ☐ Yes ☐ No

Is there anything else you would like us to know that would help us to best serve your needs?

_____

_____