## Adult Patient Profile

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td></td>
</tr>
<tr>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>Person Completing Form</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Emergency Contact</td>
<td></td>
</tr>
<tr>
<td>Phone No.</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City &amp; Zip</td>
<td></td>
</tr>
<tr>
<td>Home Phone</td>
<td></td>
</tr>
<tr>
<td>Cell Phone</td>
<td></td>
</tr>
<tr>
<td>Work Phone</td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td></td>
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</tbody>
</table>

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, etc.)
- __________________________________________
- __________________________________________
- __________________________________________

## Health History

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches/Migraines</td>
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<td></td>
</tr>
<tr>
<td>Concussion</td>
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</tbody>
</table>

| Other:                            |     |    |

### 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.

<table>
<thead>
<tr>
<th>Surgery/Procedure</th>
<th>Month/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
</tbody>
</table>

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.)

<table>
<thead>
<tr>
<th>Allergen</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
</tbody>
</table>
### Medications:

**Are you currently taking any medication?**
- [ ] Yes
- [ ] No

If yes, please list below.

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

### Previous Therapies:

<table>
<thead>
<tr>
<th>Type of Therapy</th>
<th>Dates</th>
<th>Agency</th>
<th>Name of Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological/Counseling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Rehab</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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:

<table>
<thead>
<tr>
<th>Marital Status:</th>
<th>Single</th>
<th>Married</th>
<th>Divorced</th>
<th>Widowed</th>
</tr>
</thead>
</table>

Children (how many): __________ Ages: ______________________

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

If yes, please explain: __________________________________________________________

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
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</tbody>
</table>

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
- Distractable
- 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?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Do you use the internet/email?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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

______________________________________________________________________________________________________

______________________________________________________________________________________________________