SSMHealth
Day Institute
A service of SSM Health Rehabilitation Hospital

Patient Name: ____________________________

Account Number: ____________________________

SSM Day Institute Medical History/Screening Form

To be completed by the patient / family

Patient Name:____ DOB:______________________________

Emergency Contact:___________________________________ Telephone # :__________________________

Religious/Cultural Needs: NO ☐ YES ☐ Please Explain:_____________________________________

Special Learning Needs: NO ☐ YES ☐ Please Explain:_____________________________________

Spoken Language: __________________________Prefered language for heathcare information______________________

Ethnicity____

Why are you here?____

MEDICAL INFORMATION

PLEASE CHECK YES OR NO	YES	NO		YES	NO
Hypertension/High Blood Pressure	☐	☐	Skin Sensitivity	☐	☐
Hypotension/Low Blood Pressure	☐	☐	Are you currently pregnant?	☐	☐
Light-Headedness / Dizziness	☐	☐	Arthritis / Rheumatoid Arthritis	☐	☐
Emphysema/Asthma/Short of Breath	☐	☐	Blood Born Disease:	☐	☐
Bleeding / Bruising (recent history)	☐	☐	Hepatitis B / C / HIV / AIDS	☐	☐
History of : diabetes	☐	☐	Pacemaker	☐	☐
tumors / growths	☐	☐	**Cardiovascular disease**:		
Swelling Of Extremities	☐	☐	Chest Pain /Angina /MI /CHF	☐	☐
Active seizure disorder	☐	☐	**Neurological Disease**:		
Hypoglycemia /Low Blood Sugar	☐	☐	Brain Injury / MS / Stroke / SCI	☐	☐
Osteoporosis	☐	☐	Urinary Urgency / Incontinence	☐	☐
Recent Fractures:	☐	☐	Cancer - present or past	☐	☐
DATE:__________ AREA:____________________			type & location:______________________________		
Joint Replacement	☐	☐			
DATE:__________ AREA:____________________			Are you in pain?	☐	☐
Alzheimers	☐	☐	(0/10 =no pain 10/10 =worst pain imaginable)		
Anxiety / Panic Attacks (recent)	☐	☐	Least amount of pain: ____/10		
Depression (recent)	☐	☐	Worst amount of pain: ____/10		

Other Medical Conditions not listed?____

If you answered yes to any of the above, are you under the care of a doctor for the condition? Yes ☐ No ☐

Allergies: ____

Recent or Relevent Surgery(s) within last 3 months - Include Dates: _____________________________________

What are your therapy goals?:____

If you need information regarding Advanced Directives, please request information regarding Advanced Directives from the registration staff.

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To be completed by the patient / family

FALL RISK ASSESSMENT*:	YES	NO
Have you fallen within the last year? If so, how many times? ___________	☐	☐
Have any of these falls resulted in an injury within the last year?	☐	☐
Are you afraid of falling?	☐	☐
Have you recently felt unsteady on your feet or in your wheelchair?	☐	☐
Do you experience dizziness or vertigo?	☐	☐
Do you have vision problems that are not corrected by glasses?	☐	☐
Do you use sedatives that affect your level of alertness during the day?	☐	☐
Do you have memory / cognitive difficulties?	☐	☐
Do you have a lower extremity disability that affects walking?	☐	☐

AS PER CMS FALL SCREENING CRITERIA

***Patient is considered a fall risk if patient has fallen two or more times in the past year**

***Patient is considered a fall risk if patient has fallen one time with resulting injury in the past year**

NUTRITIONAL SCREENING	YES	NO
Unexplained weight loss? (>5% in last 30 days)	☐	☐
Recent loss of appetite/aversion to food?	☐	☐
Do you have difficulty swallowing?	☐	☐
Decrease in food intake? (<50% for 3 days or more)	☐	☐
Are you under the care of a MD for these conditions?	☐	☐

PATIENT SIGNATURE:____**DATE:**____________________

If signature other than patient, relationship to patient (parent / guardian if minor)________________________________

This information will be used as a guide to your treatment plan.
If you need any medical follow-up, please contact your physician

To be completed by evaluating Therapist

** **FALL RISK** - Based on the therapist's judgement, a patient can be considered a fall risk if they answer yes to three or more fall risk assessment questions, or if they meet CMS screening criteria for fall risk. Clinician should issue Home Safety brochure if appropriate.*

Patient has been identified as a fall risk : yes no

If yes, fall prevention program has been implemented: yes no

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Medications: To be completed by the patient / family		
Please list all medications you are taking, even if you take them when not in this program.		
Medication Name Option #2: Provide a copy of the med list instead of writing it below.	**Medication Changes (if applicable during course of care)**	
	Date of change:	**Initials of person changing:**
1 ______	______	______
2 ______	______	______
3 ______	______	______
4 ______	______	______
5 ______	______	______
6 ______	______	______
7 ______	______	______
8 ______	______	______
9 ______	______	______
10 ______	______	______
11 ______	______	______
12 ______	______	______
13 ______	______	______
14 ______	______	______
15 ______	______	______
16 ______	______	______
17 ______	______	______
18 ______	______	______

Please complete the following. Indicate "N/A" if you have no allergies, diet needs or precautions for treatment.

Special Diet or Restrictions: ___________________________

Precautions: ___________________________

Emergency Contact #1: ___________________________ Phone: ___________________________

Emergency Contact #2: ___________________________ Phone: ___________________________

Primary Care Doctor: ___________________________ Phone: ___________________________

Therapists have reviewed the medical history form/medications with the patient upon evaluation

Physical Therapist Signature: ___________________________ Date: ___________________________

Occupational Therapist Signature: ___________________________ Date: ___________________________

Speech Therapist Signature: ___________________________ Date: ___________________________

Medical history form/medications reviewed with the patient (30 day update):

Staff Signature: ___________________________ Date: ___________________________

Medical history form/medications reviewed with the patient (60 day update):

Staff Signature: ___________________________ Date: ___________________________

Medical history form/medications reviewed with the patient (90 day update):

Staff Signature: ___________________________ Date: ___________________________