Patient: MRN: ACCT:

Shirley Ryan Abilitylab

NEW PATIENT DATA BASE – *To be completed **fully** and returned at your **next** therapy session*

Date: _____ Sex: _____ DOB: _____ Age: _____

***Diagnosis**: _____ ***Height**: _____ ***Weight**: _____

***PHYSICIAN INFORMATION**

Referring Doctor (who ordered therapy): _____ **Phone:** _____

PRIMARY CARE PHYSICIAN (PCP): _____

Phone: _____ **Fax:** _____ **Hospital:** _____

***MEDICATION INFORMATION – Please include a list of medications with dosage information on back of this form.**

PHARMACY:	**PHONE #**	**ADDRESS:**
	FAX:	

ALLERGIES: **DO YOU CARRY AN EPI-PEN? _____yes _____ no**

FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following:

Circle one	Condition	Mother	Father	Sibling(s)
YES NO	Diabetes			
YES NO	Heart Disease			
YES NO	High Blood Pressure			
YES NO	Stroke			

***RECENT HOSPITALIZATION**

HAVE YOU BEEN HOSPITALIZED RECENTLY? _____ **YES** _____ **NO** **WHEN?** _____

If yes, please answer the following questions:

	Check one: YES	NO
Were you placed in isolation (a private room with a sign on the door) during your recent hospital stay?		
Were you treated with antibiotics (for infection) during your recent hospital stay? If yes, where was the infection?		
Do you presently have any wounds?		
Are you being treated for these wounds?		
Do you have diarrhea now?		
Are you on antibiotics for your diarrhea?		
Do you have a tracheotomy?		
Do you have a feeding tube?		

***PHYSICAL PRECAUTIONS** Please check if your doctor put you on any physical restrictions

❒ Weight-lifting ❒ Weight-bearing (lower extremities) ❒ Cardiac ❒ Swallowing

❒ Spinal (lifting/back pain) ❒ Other _____

***PREVIOUS HISTORY**

Tobacco use? _____ yes _____ no

Packs per day? _____ How many years? ___

Alcohol use? _____ yes _____ no

How much? _____ How often? _____

**** Please fill out each section completely***