COVENANT HealthCare

Covenant HealthCare
1447 North Harrison
Saginaw, MI 48602

PF01926 (R 7/08)

ASSESSMENT/PATIENT HISTORY/PM&R

PATIENT I.D.

Please list any ALLERGIES here: ____________________

And your REACTION here: ____________________

Medical History

Please check if you have ever had:

- ☐ Heart Disease
- ☐ Cancer
- ☐ Heart Attack
- ☐ Diabetes
- ☐ Chronic Bronchitis or Emphysema
- ☐ Sickle Cell
- ☐ MRSA
- ☐ Sleep Disorders
- ☐ Peripheral Vascular Disease
- ☐ Neurological Disorder
- ☐ Brain Injury/Concussion
- ☐ Hiatal Hernia
- ☐ Congestive Heart Failure
- ☐ Stroke
- ☐ Migraine Headache
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ VRE
- ☐ Liver Problem
- ☐ Kidney Disease
- ☐ Dementia
- ☐ Angina
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Psychological Disorder
- ☐ Depression/Anxiety
- ☐ Blood Disorder
- ☐ Skin Problems
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Glaucoma
- ☐ Dialysis
- ☐ Asthma

Other: ____________________

Surgical/Procedural History

Please check if you have ever had:

- ☐ Bowel or Abdominal Surgery
- ☐ Appendectomy
- ☐ Gall Bladder Surgery
- ☐ Hernia Repair
- ☐ General Surgery
- ☐ Heart or Lung Surgery
- ☐ Tonsillectomy
- ☐ Adenoidectomy
- ☐ Orthopedic Surgery
- ☐ Knee Surgery
- ☐ Shoulder Surgery
- ☐ Hip Surgery
- ☐ Spine Surgery
- ☐ Cardiac Cath/CABG
- ☐ Pacemaker or AICD
- ☐ ASD Repair
- ☐ Cataract Removal
- ☐ Colonoscopy
- ☐ Hysterectomy
- ☐ C-Section
- ☐ D & C
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Vascular

Other: ____________________

Activities of Daily Living

Please answer the following questions:

Live in 1 or 2 level home? ____________

Are there steps to porch or in the home? ____________

Use an assistive device to walk? ☐ Yes or ☐ No

Use a tub chair? ☐ Yes or ☐ No

Does tub have a ☐ Curtain or ☐ Door

Do you use a raised toilet seat? ☐ Yes or ☐ No

First floor living? ☐ Yes or ☐ No

Do the steps have a rail? ☐ Yes or ☐ No

Need help at home? ☐ Yes or ☐ No

Live alone? ☐ Yes or ☐ No

With who? ____________________

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Have you received any home health or therapy in the last calendar year? ☐ Yes or ☐ No
If yes, when and where? ______________________________

____

Current Problems/Limitations/Symptoms:
(Check the areas that you are having trouble with)

☐ Bed Mobility	☐ Reaching
☐ Bending Back	☐ Community Activities
☐ Bending Knee	☐ Standing ________ (How Long)
☐ Bending Over	
☐ Childcare	☐ Sitting ________ (How Long)
☐ Dressing Self	
☐ Driving	☐ Walking ________ (How Long)
☐ Household Chores	
☐ Sleeping	☐ Stairs

When did the problem begin? ______________

What happened?

☐ Gradually Started	☐ Car Accident
☐ Pulling Something	☐ Reaching
☐ Fall	☐ Tripped without Falling
☐ Twisted	☐ Lifting Something
☐ Work Related	☐ Carrying Something
☐ Other:	☐ Transferring

____

____

Do you have pain? ☐ Yes or ☐ No
Where? ______________________________

Occupation: ______________________________
Education Completed: ______________________________

What are your **goals** for therapy?

____

____

____

Your List of **Medications:**
(If you have a list, we can make a copy)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________
11. ______________________________
12. ______________________________
13. ______________________________
14. ______________________________
15. ______________________________
16. ______________________________

Patient Signature ______________________ **Therapist Signature** ______________________