Braintree Rehabilitation Hospital

Facility Name: ______________________

ADDRESSOGRAPH

PATIENT INFORMATION RECORD

GENERAL INFORMATION

Patient Name ______________ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Name of Parent/Guardian ______________ Relationship ______________ Home/Work Phone ______________
Social Security Number ______________ Primary Care Physician ______________
Address ______________ City ______________ State ______________ Zip ______________
Occupation ______________ Last day worked ______________
Employer ______________ Address ______________ Phone ______________
Emergency Contact ______________ **Relationship** ______________ **Home/Work Phone** ______________

What is the problem that brings you to therapy? ______________

Is your condition due to: ☐ Auto Accident ☐ Fall ☐ Work Injury ☐ Other ______________ Date of onset ______________
Prior therapy for this condition: ☐ Inpatient Rehab ☐ yes ☐ no ☐ HealthSouth Facility ☐ yes ☐ no
☐ Outpatient Rehab ☐ yes ☐ no ☐ Other ______________ ☐ yes ☐ no

If this is a workman's comp injury, where were you working when the injury occurred? ______________

If your primary insurance is Medicare and you have sustained an injury, please describe in detail how and where this injury occurred: ______________

Primary Caregiver/Support System:

Phone:

Known Allergies:

Adverse Reactions to Medications:

CURRENT MEDICATIONS

DRUG	DOSAGE/FREQUENCY	DRUG	DOSAGE/FREQUENCY

MEDICAL/SURGICAL HISTORY

	Yes	No	Comments		Yes	No	Comments
Tuberculosis (TB)				**Diabetes Mellitus**			
Respiratory (COPD)				**Cancer**			
Asthma				**Kidney/Urinary**			
High Blood Pressure				**Epilepsy/Seizures**			
Low Blood Pressure				**Stomach/Gastrointestinal**			
Dizziness				**Heart Attack**			
Heart Disease				**Stroke**			
Circulation/Vascular				**Skin Problems**			
Arthritis				**Pacemaker**			
Osteoporosis				**Intestinal Trauma**			
Joint Replacement				**Psychiatric History**			
Pregnancy				**Other**			

Major surgical procedure within the last 60 days (e.g., craniotomy, laminectomy)? ☐ No ☐ Yes ______________

List Prior Surgeries/Hospitalization and Dates ______________

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Braintree Rehabilitation Hospital

Facility Name: ______________________

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PATIENT INFORMATION RECORD

OTHER							
DO you have problems with:	Yes	No	Comments	**Do you have problems with:**	Yes	No	Comments
Bowel Control				Depression			
Bladder Control				Sleeping			
Headaches				Fatigue			
Blurry Vision/Double Vision				Weight Loss or Gain			
Ringing in Ears				Swallowing			
Shortness of Breath				Chest Pain			
Skin				Nausea or Vomiting			
Cough / Sneezing				Swelling/Edema			

Do you smoke? ☐ No ☐ Yes How much? ______ Do you drink alcohol? ☐ No ☐ Yes How much? ______

Specify any religious / cultural considerations:

COMMENTS:

Is there anything we need to know that is not covered on this form? ☐ No If so, please explain.

Patient's Goals For Treatment:

Only For those patients under age 21:

What childhood diseases have you had? ☐ Measles ☐ Chicken Pox ☐ Mumps ☐ Rubella

Have you been exposed to any of these in the past three weeks? ☐ No ☐ Yes Explain: ______

Circle those completed: DPT #1 #2 #3 OPV #1 #2 #3 TB Skin Test ______

MMR: ______ HIB vaccine #1 #2 #3 Boosters: ______

Have you applied for state funded early intervention/services? ☐ No ☐ Yes

Name of school and day care (as applicable): ______ Phone: ______

In order to reach your optimum rehabilitation, it is essential that you follow your physician's prescribed treatment and the treatment plan established by your therapist.

If you must cancel an appointment, please notify us as soon as possible so that we can reschedule your missed appointment within the week. We appreciate notification of cancellations 24 hours prior to scheduled appointments; this allows us to utilize your appointment time for other patients.

We are obligated to record all cancellations and no shows in your medical record. If you are covered by worker's compensation, we are obligated to report cancelled and "no show" appointments to your insurance carrier.

☐ **Patient/caregiver unable to complete form; information reviewed and completed by clinician.** ______ **initials**

Signature of Person Completing Form: ______ **Date:** ______

Clinician Signature/Title/Initials **Date**

Clinician Signature/Title/Initials **Date**

Clinician Signature/Title/Initials **Date**

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