Cardinal Hill Rehabilitation Hospital
Center for Outpatient Therapy Services
Interdisciplinary Admission Assessment
Medical History

Client Information Label

Date of Evaluation: _____Onset Date: _____Admission Diagnosis: _____

In case of an emergency, which hospital do you prefer? _____

MEDICAL HISTORY

Please check all that apply to your medical history:

☐ ADHD (Attention Deficit Hyperactivity Disorder) ☐ Cerebral Palsy ☐ High Blood Pressure ☐ Otitis Media (ear infections) ☐ Spina Bifida

☐ Amputee ☐ Closed Brain Injury ☐ Incontinence ☐ Premature at birth ☐ Spinal cord injury

☐ Anoxia ☐ Congestive Heart Failure ☐ Learning Disabilities ☐ Seizures/convulsions ☐ Stroke

☐ Arthritis ☐ Developmental Delay ☐ Lung and Breathing Problems ☐ Sensory Integration ☐ Substance Abuse

☐ Cancer ☐ Diabetes ☐ Orthopedic Injuries ☐ Smoking : Date quit _____

☐ Cardiac Problems ☐ Down Syndrome ☐ Other: _____

Past Surgeries/Hospitalizations (and dates): _____

_____

Have you had a TB Skin Test? ☐ Yes ☐ No Date of Test:_____ Results: ☐ Positive ☐ Negative

If positive, action taken: _____

List **ALL MEDICINES** you are now taking: (if none, check here ☐)

Name of Medicine	Dosage	Frequency	Side Effects	Prescribing MD and Phone Number

Allergies: (List anything that you are allergic to including medications) _____

_____

What role/part do you play in your family? (ie, worker, chores, hobbies): _____

Do you have any religious or cultural traditions that we need to attempt to accommodate?_____

Hearing Problems: ☐ Yes ☐ No Last exam_____ Hearing Aides: ☐ Yes ☐ No Comments: _____

Vision Problems: ☐ Yes ☐ No Last exam_____ Glasses: ☐ Yes ☐ No Comments: _____

Education Level: _____ Current Grade Level: _____

Work History: _____ Retired: ☐ Yes ☐ No On Disability: ☐ Yes ☐ No

Client's goals for therapy: _____

_____

Team Member Signatures/Initials:

_____ _____

_____ _____

_____ _____