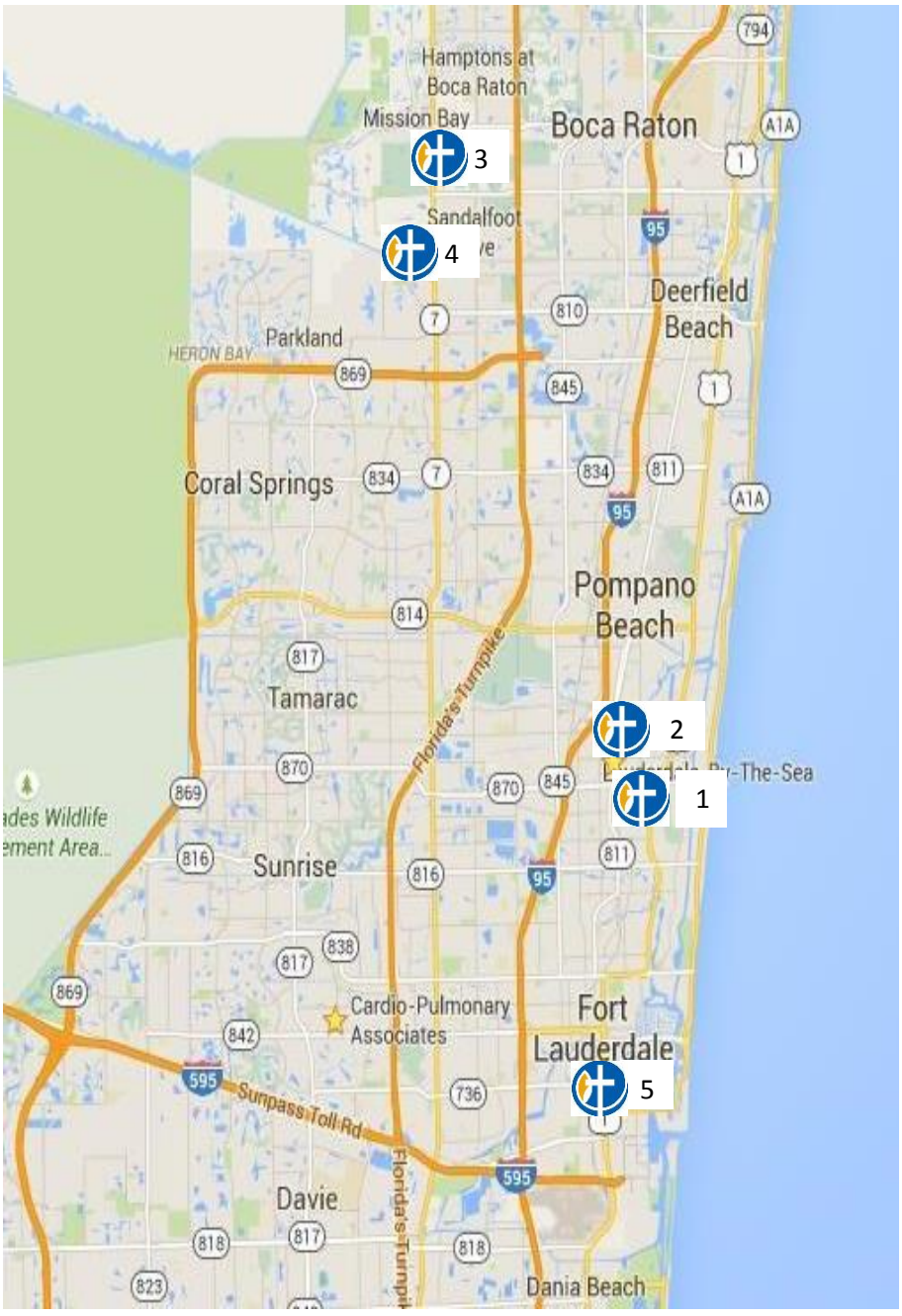
Thank you for choosing Holy Cross Outpatient Rehabilitation

- Please complete the attached paperwork prior to your arrival.
- Ensure you know which facility you are scheduled for.
- Please arrive **30 minutes** prior to your scheduled appointment time to complete registration.
- If you have any questions please contact the facility



(1) Holy Cross Main Hospital PT/OT/Speech
4725 N Federal Highway
954-492-5738 F: 954-776-3096
Corner of Commercial Blvd

(2) HCMG Orthopedic Institute Holy Cross HealthPlex - PT/OT/Hand
5597 North Dixie Highway
954-267-6390 F: 954-267-6398
Between Commercial & Cypress Creek

(2) Women's Health Rehab Dorothy Mangurian Comprehensive Women's Center - PT
1000 NE 56th Street
954-229-8685 F: 954-229-8692
Off Dixie north of Commercial Blvd

(3) HCMG Ortho Institute West Boca PT/OT/Hand
9970 Central Park Blvd #400A
Boca Raton
561-483-6924 F: 561-852-1997
North of Palmetto

(4) West Boca Raton Urgent Care PT
23071 State Road 7 (441) Boca Raton
561-477-6012 F: 561-482-5963

(5) HCMG Rio Vista PT
1309 S Federal Highway
954-267-6819 F: 954-776-3096
South of Davie Blvd, N of I-595

Holy Cross Home Health
954-267-7000

(1) Zachariah Wellness Pavilion
954-229-7950

Name: _____ Date: _____

Date of onset of: ❑ Injury ❑ Problem ❑ Surgery _____

State your main reason for therapy: _____

Do you now have, or have you ever had any of the following?

High Blood Pressure	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No
Pacemaker	❑ Yes	❑ No	Seizures	❑ Yes	❑ No
Dizziness/Fainting	❑ Yes	❑ No	Fractures	❑ Yes	❑ No
Osteoporosis	❑ Yes	❑ No	Circulatory Problems	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Recent Weight Change	❑ Yes	❑ No
Bowel/Bladder Problems	❑ Yes	❑ No	Swallowing Problems	❑ Yes	❑ No
Kidney Problems	❑ Yes	❑ No	H/O Falls	❑ Yes	❑ No
Stroke/Mini Stroke	❑ Yes	❑ No	Hip Replacement	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No	Knee Replacement	❑ Yes	❑ No
Heart Problems	❑ Yes	❑ No	Other	❑ Yes	❑ No

If **YES** to any of the above, please explain: _____

_____

_____

Please list any other significant medical diagnoses or conditions:_____

_____

_____

Please list any previous surgical, operative or invasive procedures that you have had: _____

_____

_____

Please list any medications including long term, current, over-the-counter or herbal preparations that you are currently taking:

_____

_____

Please describe any known adverse and allergic drug reactions: _____

_____

Is this problem related to a motor vehicle accident? ❑ Yes ❑ No If **YES**, when? _____

Have you had this problem before? ❑ Yes ❑ No If **YES**, when? _____

If YES, did you receive therapy for this problem? ❑ Yes ❑ No If **YES**, what treatment helped you? _____

_____

Has this problem limited your ability to perform everyday task? ❑ Yes ❑ No If **YES**, what are they? _____

_____

What are your goals for therapy? Be specific: _____

_____

PATIENT INFORMATION – REHABILITATION SERVICES

PAIN SCREEN

1. Do you have pain now? ❑ Yes ❑ No

2. If no, have you had pain in the last 24 hours or past few days, weeks or months? ❑ Yes ❑ No

If the answer is **NO** to both questions, **STOP NOW!**

If the answer is YES to either question, continue below:

3. Is the pain you are experiencing of related to your **current reason** for therapy? ❑ Yes ❑ No

If the answer to question #3 is **YES**, complete the INITIAL PAIN ASSESSMENT.

INITIAL PAIN ASSESSMENT	Location 1	Location 2	Location 3	Location 4
Location: Where do you have pain?				
Quality: What does your pain feel like for each location? (throbbing, tender shooting, stabbing, sharp, cramping, burning, aching, heavy, etc.)				
Intensity: On a scale of 0-10 with 0 being "no pain" and 10 being the "worst pain ever," Rate your pain as it feels now.				
Rate your pain at its best: (0-10)				
Rate your pain at its worst: (0-10)				
What is your goal for pain intensity?				
Time/Frequency: When did the pain start?				
Is the pain **constant** (always there) or **intermittent** (comes and goes)?				
What positions, situations help **alleviate** (ease) your pain?				
What activities or situations **aggravate** or makes your pain worse?				

What alternative therapies have you tried? ❑ NONE ❑ Cold ❑ Heat ❑ Massage

❑ Other: _____ What works well? _____ Works poorly? _____

All of this information has been reviewed with the patient and/or family: ❑ Yes

_____ _____

Signature of Person Completing Form Date

_____ _____

Staff Signature Date

Neck Disability Index Questionnaire

Name:_____ Date:_____/_____/_____ Score:_____

This questionnaire is designed to help your Physical Therapist understand how much your neck pain has affected your ability to manage in everyday life. Please answer each section and mark only **ONE BOX** which best applies to you at this moment.

PAIN INTENSITY

□I have no pain at the moment
□The pain is very mild at the moment
□The pain is moderate at the moment
□The pain is fairly severe at the moment
□The pain is very severe at the moment
□The pain is worst imaginable at the moment

PERSONAL CARE

□I would not have to change my way of washing or dressing to avoid pain
□I can look after myself normally but it causes extra pain
□It is painful to look after myself and I am slow and careful
□I need some help, but manage most of my personal care
□I need help every day in most aspects of self-care
□I do not get dressed. I wash with difficulty and stay in bed

LIFTING

□I can lift heavy weights without extra pain
□I can lift heavy weights but it causes extra pain
□Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, like on a table
□Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
□I can lift very light weights
□I cannot lift or carry anything at all

READING

□I can read as much as I want with no pain in my neck
□I can read as much as I want with slight pain in my neck
□I can read as much as I want with moderate pain in my neck
□I cannot read as much as I want because of moderate pain in my neck
□I cannot read as much as I want because of severe pain in my neck
□I cannot read at all

Neck Disability Index Questionnaire

HEADACHES

□I have no headaches at all
□I have slight headaches which come infrequently
□I have moderate headaches which come frequently
□I have moderate headaches which come infrequently
□I have severe headaches which come frequently
□I have headaches almost all the time

DRIVING

□I can drive my car without neck pain
□I can drive my car as long as I want with slight pain in my neck
□I can drive my car as long as I want with moderate pain in my neck
□I cannot drive my car as long as I want because of moderate pain in my neck
□I can hardly drive because of severe pain in my neck
□I cannot drive my car at all.

CONCENTRATION

□I can concentrate fully with no difficulty
□I can concentrate fully with slight difficulty
□I have a fair degree of difficulty concentrating
□I have a lot of difficulty concentrating
□I have a great deal of concentrating
□I cannot concentrate at all

SLEEPING

□I have no trouble sleeping at all
□My sleep is slightly disturbed (less than 1 hour)
□My sleep is mildly disturbed (1-2 hours)
□My sleep is moderately disturbed (2-3 hours)
□My sleep is greatly disturbed (3-5 hours)
□My sleep is completely disturbed (5-7 hours)

WORK

□I can do as much work as I want to
□I can only do my usual work, but no more
□I can do most of my usual work, but no more
□I cannot do my usual work
□I can hardly do any work at all
□I cannot do any work at all

RECREATION

□I am able to engage in all recreational activities with no pain in my neck at all
□I am able to engage in all recreational activities with some pain in my neck
□I am able to engage in most, but not all recreational activities because of pain in my neck
□I am able to engage in a few of my usual activities because of my neck pain
□I can hardly do any recreational activities because of my neck
□I cannot do any recreational activities at all