



ST. MARY MERCY LIVONIA

SAINT JOSEPH MERCY HEALTH SYSTEM

Physical Medicine and Rehabilitation Outpatient Medical History/Data Base



It is important for your therapist to **maximize your treatment sessions** by focusing on your main functional deficit. It is difficult to effectively treat more than one diagnosis at a time. If your doctor has ordered treatment for multiple diagnoses your therapist will **focus treatment on your main functional deficit** and other diagnoses will be addressed as time allows. Our goal is to provide quality care to achieve the highest functional outcome.

Name: _____ Date: _____
Home Telephone: _____ Work Telephone: _____

Leave statements blank that do not apply.

SELF-CARE SKILLS	Easy To Do	Some Difficulty	Hard To Do	Unable To Do
Sleeping without Pain				
Cooking				
Eating/Swallowing				
Bathing/Showering				
Brushing Teeth/Shaving				
Combing Hair				
Putting on Shirt				
Putting on Pants/Shoes/Socks				
Fastening Buttons/Zippers				
Driving				
Participating in Work/School				
Doing Light Work (dusting, sweeping, dishes)				
Doing Heavy Work (laundry, yard work, vacuuming)				
MOBILITY:				
Sitting				
Standing				
Walking				
Pushing/Pulling				
Lifting/Carrying				
Reaching				
Stooping/Bending				
Kneeling				
Climbing Stairs				
Getting Up From Toilet				
COMMUNICATION:				
Following Directions				
Talking on Telephone				
Reading Newspaper				
Writing Messages				
Remembering Information				

MEDICAL HISTORY		
Heart Problems	YES	NO
Angina	YES	NO
Pacemaker	YES	NO
High/Low Blood Pressure	YES	NO
Blood Clotting Problems	YES	NO
Breathing Problems	YES	NO
Diabetes	YES	NO
Cancer	YES	NO
Fractures	YES	NO
Stroke	YES	NO
Seizures	YES	NO
Vision Problems	YES	NO
Hearing Problems	YES	NO
Current Pregnancy	YES	NO
Surgery Related to Problem	YES	NO
Explain: _____		
Previous Therapy	YES	NO
Explain: _____		
Medications: _____		

Allergies: _____		
Bee Stings	YES	NO
Betadine/Iodine	YES	NO
Corn	YES	NO
Latex	YES	NO

Live In:	House	Apt./Condo	Other
	1-Story	2-Story or More	
	Basement:	YES	NO
Live With:	_____		
Number of Stairs Into Home:	_____		
Railings:	YES	NO	
Number of Stairs Inside Home:	_____		
Railings:	YES	NO	

