Saint Alphonsus
Rehabilitation Services

901 N. Curtis Rd., Ste 204 • Boise, ID 83706 • (208) 367-3315

Patient Name: ______________________________
DOB: __________________
Date: __________________

This profile is part of your medical record and is strictly confidential. Please answer the following questions to the best of your knowledge. Welcome to Saint Alphonsus Rehabilitation Services (STARS)!

Abbreviated Patient Profile (For 1x Evals)

Diagnosis/Conditions/Reasons you are seeking rehabilitation services:

Do you now have (or have you had) any of the following conditions? If yes, please check.

Condition		Condition	
Heart Disease	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Headaches/Migraines	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Bowel Problems	☐ Yes ☐ No
Lung Disease	☐ Yes ☐ No	Bladder Problems	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Thyroid Disorder	☐ Yes ☐ No	Bleeding Disorder	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	Asthma/Hay Fever	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Other: __________________	☐ Yes ☐ No

Medications

1.	3.	5.
2.	4.	6.

ALLERGEN	REACTION

Are you allergic to Latex? ☐Yes ☐No ☐I don't know

SURGERY/PROCEDURE	MONTH/YEAR

Have you fallen in the past year? ☐ Yes ☐ No If yes, how many times have you fallen? ______________

Are you afraid that you may fall again? ☐Yes ☐No

PAIN DESCRIPTION: *(Please Circle the Number that Describes your Level of Pain)*

No Pain ***Unbearable Pain***
0 1 2 3 4 5 6 7 8 9 10

Describe Your Pain: ☐No Pain ☐Shooting ☐Aching ☐Throbbing ☐Dull ☐Sharp ☐Burning ☐Other

Where is your pain located?

______________________________________ ______________________

Patient Signature (or Guardian if patient is under 18) **Date** **Time**