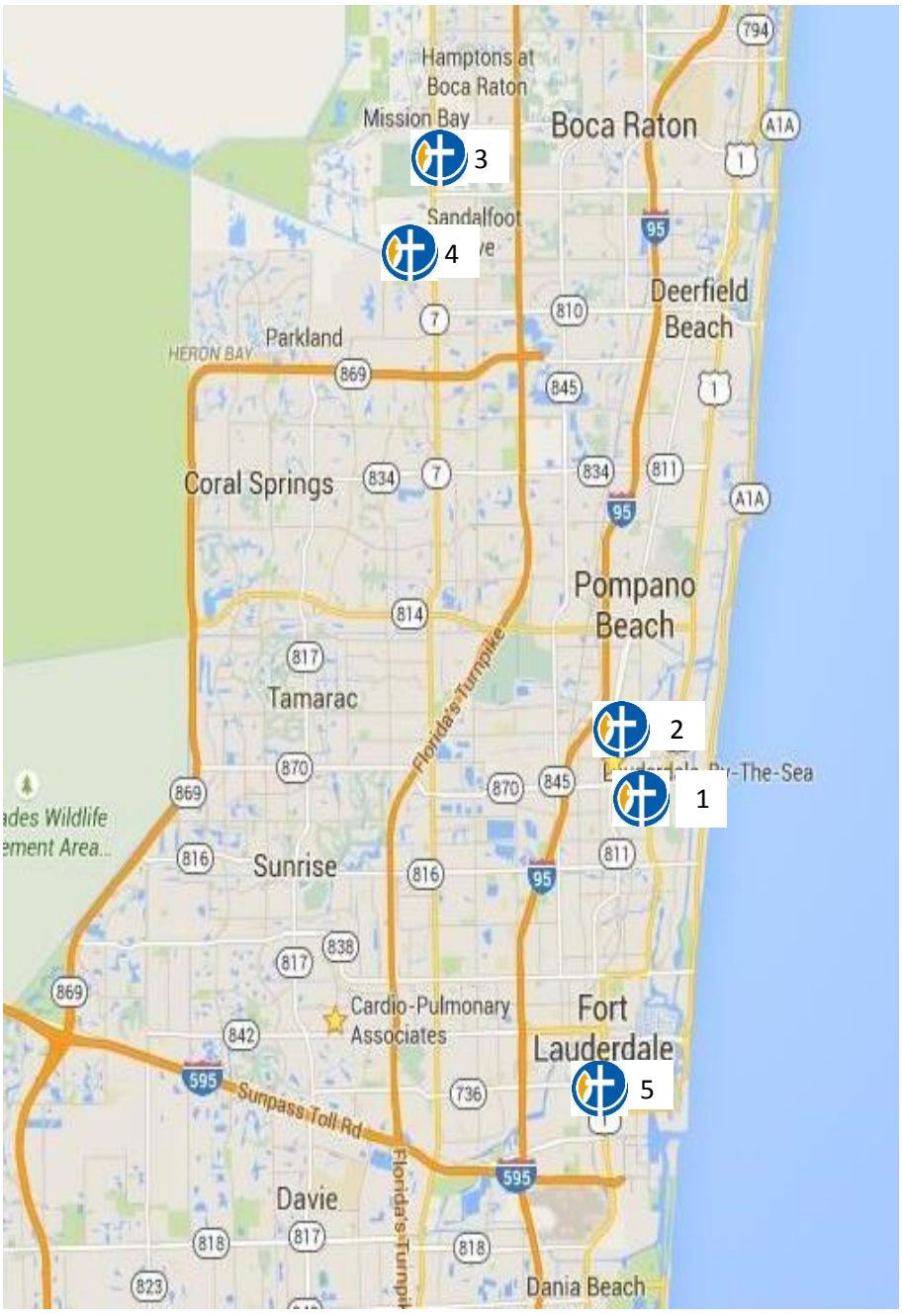
Thank you for choosing Holy Cross Outpatient Rehabilitation

- 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

Barthel Index of Activities of Daily Living

Instructions: Choose the scoring point for the statement that most closely corresponds to the patient's current level of ability for each of the following 10 items. Record actual, not potential, functioning. Information can be obtained from the patient's self-report, from a separate party who is familiar with the patient's abilities (such as a relative), or from observation. Refer to the Guidelines section on the following page for detailed information on scoring and interpretation.

The Barthel Index

Bowels
0 = incontinent (or needs to be given enemata)
1 = occasional accident (once/week)
2 = continent
Patient's Score: _____

Bladder
0 = incontinent, or catheterized and unable to manage
1 = occasional accident (max. once per 24 hours)
2 = continent (for over 7 days)
Patient's Score: _____

Grooming
0 = needs help with personal care
1 = independent face/hair/teeth/shaving (implements provided)
Patient's Score: _____

Toilet use
0 = dependent
1 = needs some help, but can do something alone
2 = independent (on and off, dressing, wiping)
Patient's Score: _____

Feeding
0 = unable
1 = needs help cutting, spreading butter, etc.
2 = independent (food provided within reach)
Patient's Score: _____

Transfer
0 = unable – no sitting balance
1 = major help (one or two people, physical), can sit
2 = minor help (verbal or physical)
3 = independent
Patient's Score: _____

Mobility
0 = immobile
1 = wheelchair independent, including corners, etc.
2 = walks with help of one person (verbal or physical)
3 = independent (but may use any aid, e.g., stick)
Patient's Score: _____

Dressing
0 = dependent
1 = needs help, but can do about half unaided
2 = independent (including buttons, zips, laces, etc.)
Patient's Score: _____

Stairs
0 = unable
1 = needs help (verbal, physical, carrying aid)
2 = independent up and down
Patient's Score: _____

Bathing
0 = dependent
1 = independent (or in shower)
Patient's Score: _____

Total Score: _____

(Collin et al., 1988)

Scoring:

Sum the patient's scores for each item. Total possible scores range from 0 – 20, with lower scores indicating increased disability. If used to measure improvement after rehabilitation, changes of more than two points in the total score reflect a probable genuine change, and change on one item from fully dependent to independent is also likely to be reliable.

Sources:

- Collin C, Wade DT, Davies S, Horne V. The Barthel ADL Index: a reliability study. *Int Disabil Stud*. 1988;10(2):61-63.
- Mahoney FI, Barthel DW. Functional evaluation: the Barthel Index. *Md State Med J*. 1965;14:61-65.
- Wade DT, Collin C. The Barthel ADL Index: a standard measure of physical disability? *Int Disabil Stud*. 1988;10(2):64-67.

Guidelines for the Barthel Index of Activities of Daily Living

General

- The Index should be used as a record of what a patient ***does***, NOT as a record of what a patient ***could do***.
- The main aim is to establish degree of independence from any help, physical or verbal, however minor and for whatever reason.
- The need for supervision renders the patient not independent.
- A patient's performance should be established using the best available evidence. Asking the patient, friends/relatives, and nurses will be the usual source, but direct observation and common sense are also important. However, direct testing is not needed.
- Usually the performance over the preceding 24 – 48 hours is important, but occasionally longer periods will be relevant.
- Unconscious patients should score '0' throughout, even if not yet incontinent.
- Middle categories imply that the patient supplies over 50% of the effort.
- Use of aids to be independent is allowed.

Bowels (preceding week)

- If needs enema from nurse, then 'incontinent.'
- 'Occasional' = once a week.

Bladder (preceding week)

- 'Occasional' = less than once a day.
- A catheterized patient who can completely manage the catheter alone is registered as 'continent.'

Grooming (preceding 24 – 48 hours)

- Refers to personal hygiene: doing teeth, fitting false teeth, doing hair, shaving, washing face. Implements can be provided by helper.

Toilet use

- Should be able to reach toilet/commode, undress sufficiently, clean self, dress, and leave.
- 'With help' = can wipe self and do some other of above.

Feeding

- Able to eat any normal food (not only soft food). Food cooked and served by others, but not cut up.
- 'Help' = food cut up, patient feeds self.

Transfer

- From bed to chair and back.
- 'Dependent' = NO sitting balance (unable to sit); two people to lift.
- 'Major help' = one strong/skilled, or two normal people. Can sit up.
- 'Minor help' = one person easily, OR needs any supervision for safety.

Mobility

- Refers to mobility about house or ward, indoors. May use aid. If in wheelchair, must negotiate corners/doors unaided.
- 'Help' = by one untrained person, including supervision/moral support.

Dressing

- Should be able to select and put on all clothes, which may be adapted.
- 'Half' = help with buttons, zips, etc. (*check!*), but can put on some garments alone.

Stairs

- Must carry any walking aid used to be independent.

Bathing

- Usually the most difficult activity.
- Must get in and out unsupervised, and wash self.
- Independent in shower = 'independent' if unsupervised/unaided.

(Collin et al., 1988)