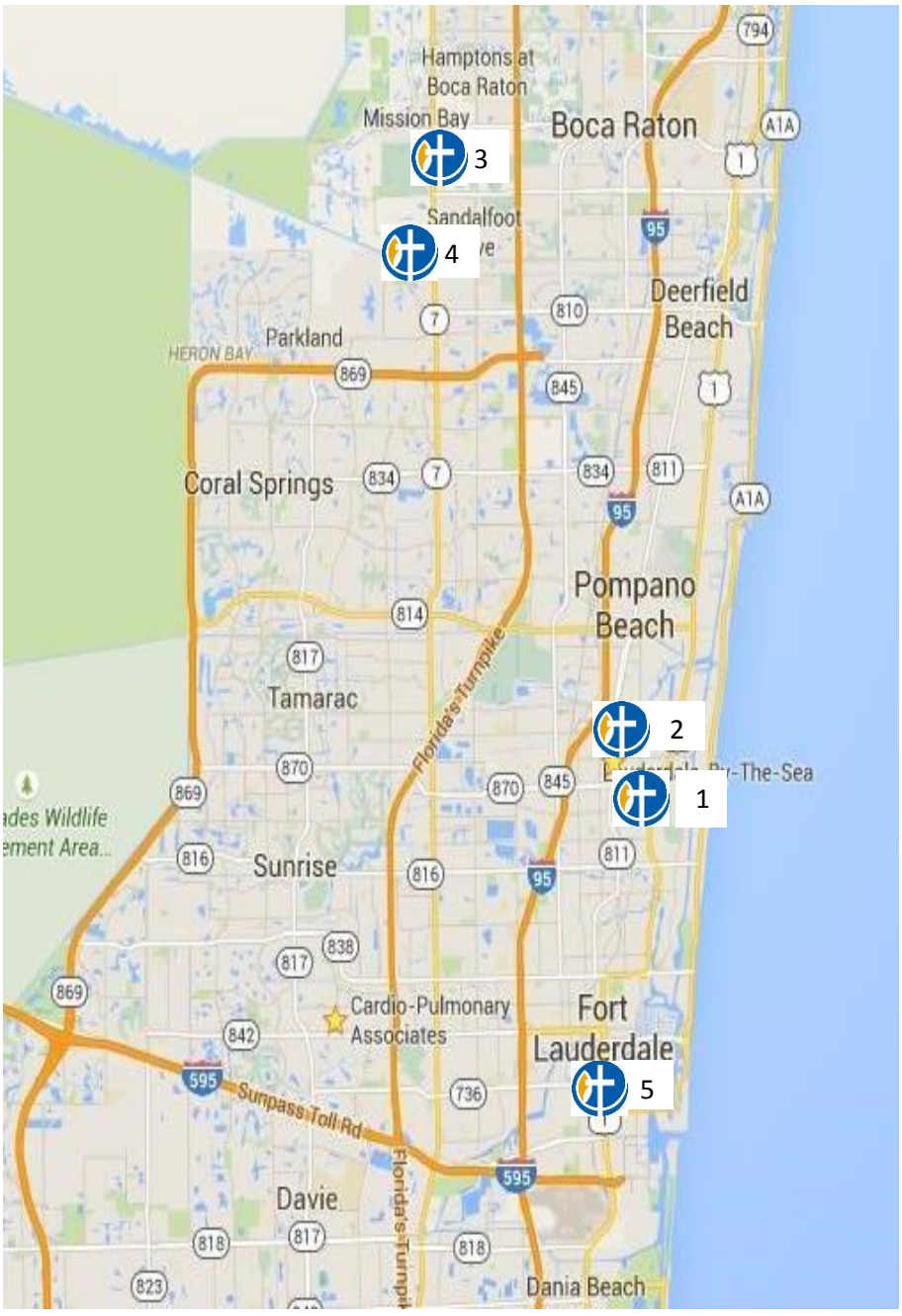
Thank you for choosing Holy Cross Outpatient Rehabilitation

- Please complete the attached paperwork prior to your arrival.
- Ensure you know which facility you are scheduled for.
- Please arrive 20 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: 561-488-3508

(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

Lower Extremity Functional Index

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower extremity pain for which you are currently seeking attention.

Do you, or would you have any difficulty with the following activities:

(Circle one number on each line)

	Extreme difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
a. Any of your usual work, housework or school activities.	**0**	**1**	**2**	**3**	**4**
b. Your usual hobbies, recreational or sporting activities.	**0**	**1**	**2**	**3**	**4**
c. Getting into or out of the bath.	**0**	**1**	**2**	**3**	**4**
d. Walking between rooms.	**0**	**1**	**2**	**3**	**4**
e. Putting on your shoes or socks.	**0**	**1**	**2**	**3**	**4**
f. Squatting.	**0**	**1**	**2**	**3**	**4**
g. Lifting an object, like a bag of groceries from the floor**.**	**0**	**1**	**2**	**3**	**4**
h. Performing light activities around your home.	**0**	**1**	**2**	**3**	**4**
i. Performing heavy activities around your home.	**0**	**1**	**2**	**3**	**4**
j. Getting into or out of a car.	**0**	**1**	**2**	**3**	**4**
k. Walking 2 blocks.	**0**	**1**	**2**	**3**	**4**
l. Walking a mile.	**0**	**1**	**2**	**3**	**4**
m. Going up or down 10 stairs (about 1 flight of stairs).	**0**	**1**	**2**	**3**	**4**
n. Standing for 1 hour.	**0**	**1**	**2**	**3**	**4**
o. Sitting for 1 hour.	**0**	**1**	**2**	**3**	**4**
p. Running on even ground.	**0**	**1**	**2**	**3**	**4**
q. Running on uneven ground.	**0**	**1**	**2**	**3**	**4**
r. Making sharp turns while running fast.	**0**	**1**	**2**	**3**	**4**
s. Hopping.	**0**	**1**	**2**	**3**	**4**
t. Rolling over in bed.	**0**	**1**	**2**	**3**	**4**
COLUMN TOTALS					

Score variation ± 6 LEFTS points MDC
& MCID = 9 LEFS points

Score _____/80