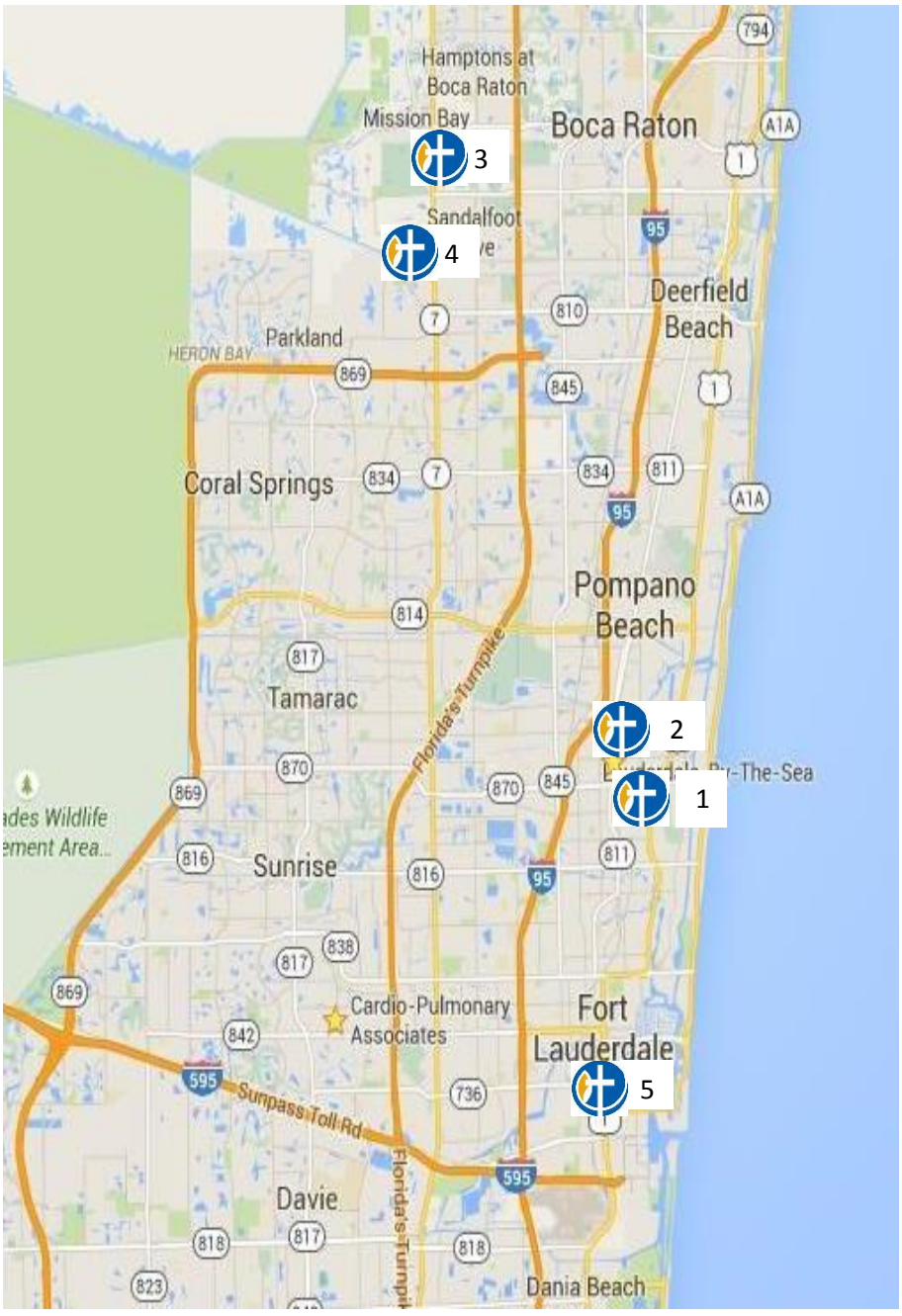
Thank you for choosing Holy Cross Outpatient Rehabilitation

- 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

Lysholm Knee Questionnaire / Tegner Activity Scale

Name: First Last **Date:**

Physician:

1. Limp:

- ◯ a) None
- ◯ b) Slight or periodical
- ◯ c) Severe and constant

2. Support:

- ◯ a) None
- ◯ b) Stick or crutch
- ◯ c) Weight-bearing impossible

3. Locking:

- ◯ a) No locking and no catching sensations
- ◯ b) Catching sensation but no locking
- ◯ c) Locking occasionally
- ◯ d) Locking frequently
- ◯ e) Locked joint on examination

4. Instability:

- ◯ a) Never giving way
- ◯ b) Rarely during athletics or other severe exertion
- ◯ c) Frequently during athletics or other severe exertion (or incapable of participation)
- ◯ d) Occasionally in daily activities
- ◯ e) Often in daily activities
- ◯ f) Every step

5. Pain:

- ◯ a) None
- ◯ b) Inconstant and slight during severe exertion
- ◯ c) Marked during severe exertion
- ◯ d) Marked on or after walking more than 2 km
- ◯ e) Marked on or after walking less than 2 km
- ◯ f) Constant

6. Swelling:

- ◯ a) None
- ◯ b) On severe exertion
- ◯ c) On ordinary exertion
- ◯ d) Constant

7. Stair-climbing:

- ◯ a) No problems
- ◯ b) Slightly impaired
- ◯ c) One step at a time
- ◯ d) Impossible

8. Squatting:

- ◯ a) No problems
- ◯ b) Slightly impaired
- ◯ c) Not beyond 90°
- ◯ d) Impossible

Activity Level Before Injury	Current Activity Level	Activity Level Following Surgery if applicable	
○	○	○	Competitive sports Soccer - national and international elite
○	○	○	Competitive sports Soccer, lower divisions Ice hockey Wrestling Gymnastics
○	○	○	Competitive sports Bandy Squash or badminton Athletics (jumping, etc.) Downhill skiing
○	○	○	Competitive sports Tennis Athletics (running) Motorcross, speedway Handball Basketball Recreational sports Soccer Bandy and ice hockey Squash Athletics (jumping) Cross-country track findings both recreational and competitive
○	○	○	Recreational sports Tennis and badminton Handball Basketball Downhill skiing Jogging, at least five times per week
○	○	○	Work Heavy labor (*e.g.*, building, forestry) Competitive sports Cycling Cross-country skiing Recreational sports Jogging on uneven ground at least twice weekly
○	○	○	Work Moderately heavy labor (*e.g.*, truck driving, heavy domestic work) Recreational sports Cycling Cross-country skiing Jogging on even ground at least twice weekly
○	○	○	Work Light labor (*e.g.*, nursing) Competitive and recreational sports Swimming Walking in forest possible
○	○	○	Work Light labor Walking on uneven ground possible but impossible to walk in forest
○	○	○	Work Sedentary work Walking on even ground possible
○	○	○	Sick leave or disability pension because of knee problems

Tegner: ☐ ☐ ☐ Lysholm Score: ☐