Kona Rehab
PHYSICAL THERAPY

75-1029 Henry Street, Suite 101
Kailua-Kona, HI 96740
Ph: (808) 334-0806 / Fax: (808) 334-0483

Subjective Medical History

Patient Name:	Date:
Birthdate:	Occupation:
Referred by:	Primary Care Physician:

Nutritional Screen:

Weight:_____ Weight loss – within last 6 mos If yes, please explain: _____
Height:_____ Weight gain – within last 6 mos If yes, please explain: _____

History of Condition

When did the injury occur?
First episode:_____
Second episode:_____
Third episode:_____

How did the injury or problem occur? _____
_____
Have you been treated for this injury or problem before:
_____
If yes, explain: _____

Test / Treatments

Have you been hospitalized for this condition? _____ If yes, approximate date: _____
Have you had surgery for this condition? _____ If yes, approximate date: _____
Have you had any injections? _____ If yes, approximate date: _____

Please list any diagnostic tests you have had for this condition and its findings (e.g. MRI, Xray, CT scan, etc):
_____

What are your current symptoms? (pain, numbness, swelling, tightness, etc) _____

What is your dominant arm? _____

Self-Management Strategies

Are you exercising at home? _____ If yes, what type? _____
Are you using heat/cold pack? _____ If yes, what type? _____
Are you wearing a sling/brace? _____ If yes, what type? _____
Do you smoke tobacco? _____ If yes, how much? _____

LOSS OF BALANCE? Y/N _____ How many times? _____ Comments: _____
HISTORY OF FALLS? Y/N _____ How many times?_____ Comments: _____

Be sure to scroll to the 2nd page

Activities of Daily living - Using the scale below – From 0 – 10:

How much difficulty do you have with the following tasks

NA = Doesn't Apply 0 = No difficulty 5 = Somewhat difficult 10 = Unable

Lying Down _____
Sitting _____
Walking _____
Squatting _____
Standing _____

Going downstairs _____
Lifting/carrying _____
Jogging/running _____
Overhead reaching _____
Going upstairs _____

Housework _____
Yardwork _____
Dressing _____
Kneeling _____
Driving a car _____

Work

Are you currently working?Y/N: _____ Full/Part time: _____Is this a work injury? Y/N: _____
Who is your employer? _____What is your job title? _____What type of work? _____

What critical work duties have been most affected by your problem? _____

How many days of work have you missed due to this injury or problem? _____

Recreation

What type of activities are you involved with? _____
How often do you participate in such activities? _____

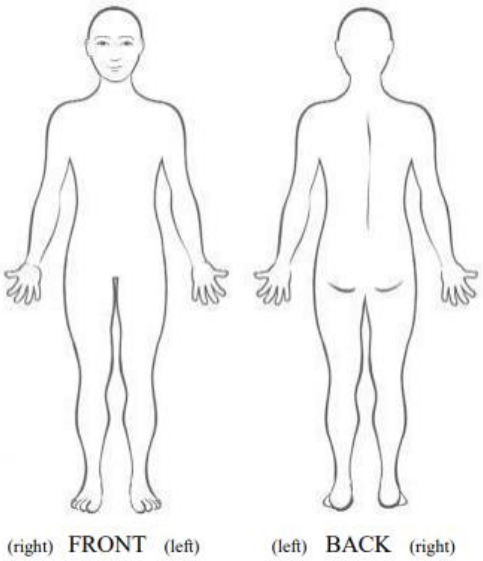
Plan of care:

Do you have a follow-up scheduled with your physician? _____ If yes, when? _____
May we discuss or disclose your health information to your family and other caregivers? _____
With whom? _____

Goals: What physical improvement at the end of therapy would leave you highly satisfied with our services?

_____

PAIN DIAGRAM



LEGEND FOR DIAGRAM:	Ache: /\/\/\/\	Numbness: ====
Pins/Needles: 0000	Burning: XXXX	Stabbing: /////

Rate your pain using a 0-10 scale:
0=No pain 5=Moderate 10=Severe
Today's pain: _____
Worst pain since onset _____
Best pain since onset _____
What percentage of time do you feel pain? _____
Is there pain present at night? Y/N: _____
What position helps you sleep? _____
What makes your problem BETTER? _____
What makes your problem WORSE? _____

To the best of my knowledge and belief, the information I provided is complete and true.
I hereby give my consent to receive therapy services at Kona Rehab.scabilin

_____

Patient E-Signature: Date:

_____

Therapist Signature Date:

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Medication and Precautions List

Patient Name: ______________________________________ Date: __________

Please list all medications, including all prescription, over the counter medications, herbals, vitamins, minerals, and dietary supplements. Include the dosage, frequency, and administration method for each medication.

See attached list

Medication	Dosage	Frequency	Method of Administration
		As Needed Once Daily Twice Daily Three x Daily Other:	Oral Sublingual Topical Subcutaneous Injection Other:
		As Needed Once Daily Twice Daily Three x Daily Other:	Oral Sublingual Topical Subcutaneous Injection Other:
		As Needed Once Daily Twice Daily Three x Daily Other:	Oral Sublingual Topical Subcutaneous Injection Other:
		As Needed Once Daily Twice Daily Three x Daily Other:	Oral Sublingual Topical Subcutaneous Injection Other:
		As Needed Once Daily Twice Daily Three x Daily Other:	Oral Sublingual Topical Subcutaneous Injection Other:
		As Needed Once Daily Twice Daily Three x Daily Other:	Oral Sublingual Topical Subcutaneous Injection Other:

Please check all that apply	Additional Description
Abnormal Blood Pressure	
Allergies (Example: drug, latex, foot, etc)	
Balance Problem or Dizziness (Vertigo, Orthostatic hypotension)	
Bowel or Bladder Control Problems	
Cancer history (Dates and type)	
Diabetes	
Heart Disease or Stroke (CHF, COPD)	
Lung or Respiratory Problem (Asthma, COPD, Emphysema)	
Neurologic Disease (Epilepsy, MS, Fibromyalgia)	
Orthopedic conditions (Osteoporosis Osteopenia, Arthritis, RA, Scoliosis)	
Pacemaker	
Recent Surgery	
Weight Bearing Restrictions	
Describe any other serious medical issues not mentioned above:	

I request to have Kona Rehab provide automatic appointment reminders. Please choose one of the following:

Please send a cell phone text message reminder to confirm my upcoming appointment.

My cell phone carrier/provider is:

AT&T Cingular T-Mobile
Boost Mobile Sprint Verizon
OTHER: _____

Please send an email message reminder to: _____

Please provide a phone call reminder to: _____

_____

Patient / Guardian Signature: Date:

_____

Reviewed by: Date: