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

PATIENT PROFILE

Welcome to STARS! This profile is part of your medical record and is strictly confidential.

Name:	**Birth Date:**	**Age:**	**Date:**

What problem brings you here? When did it start?

What is your main goal for therapy?

Please list any restrictions or precautions your doctor(s) has/have given you?

PAST/CURRENT TREATMENT FOR CONDITION

Have you had (or are you currently) receiving treatment for this condition? ☐ Yes ☐ No

If yes, when? If yes, where?

What was/is your response to the treatment? ☐ Good, it helped /is helping ☐ Poor, it did not help (is not) helping

Are you currently receiving: Nursing Home care (or skilled nursing facility)? ☐ Yes ☐ No

Home Health Services? ☐ Yes ☐ No Hospice Services? ☐ Yes ☐ No

Have you been hospitalized recently? ☐ Yes ☐ No If yes, why?

Have you had a recent: ☐ X-Ray ☐ MRI ☐ CT Scan ☐ EMG ☐ None

When? Where?

SOCIAL HISTORY

Tobacco Use	☐ Yes ☐ No # Packs/Day: _____ # of years: _____
Alcohol Use	☐ Yes ☐ No # Drinks/Day: _____ # Drinks/Week: _____
Recreational Drugs	☐ Yes ☐ No What and how often: _____

SUMMARY LIST

CONDITIONS: Have you or a family member had (or currently have) any of these conditions?

Heart Disease	☐ **Yes** ☐ **No** (☐ Me ☐ Family)	Arthritis	☐ **Yes** ☐ **No** (☐ Me ☐ Family)
Stroke	☐ **Yes** ☐ **No** (☐ Me ☐ Family)	Headaches/Migraines	☐ **Yes** ☐ **No** (☐ Me ☐ Family)
High Blood Pressure	☐ **Yes** ☐ **No** (☐ Me ☐ Family)	Bowel/Bladder Problems	☐ **Yes** ☐ **No** (☐ Me ☐ Family)
Lung Disease	☐ **Yes** ☐ **No** (☐ Me ☐ Family)	High Cholesterol	☐ **Yes** ☐ **No** (☐ Me ☐ Family)
Cancer	☐ **Yes** ☐ **No** (☐ Me ☐ Family)	Seizures	☐ **Yes** ☐ **No** (☐ Me ☐ Family)
Mental Health Issue	☐ **Yes** ☐ **No** (☐ Me ☐ Family)	Bleeding Disorder	☐ **Yes** ☐ **No** (☐ Me ☐ Family)
Kidney Disease	☐ **Yes** ☐ **No** (☐ Me ☐ Family)	Asthma/Hay Fever	☐ **Yes** ☐ **No** (☐ Me ☐ Family)
Diabetes	☐ **Yes** ☐ **No** (☐ Me ☐ Family)	Skin Disorders	☐ **Yes** ☐ **No** (☐ Me ☐ Family)
Hepatitis A	☐ **Yes** ☐ **No** (☐ Me ☐ Family)	HIV	☐ **Yes** ☐ **No** (☐ Me ☐ Family)
Hepatitis B	☐ **Yes** ☐ **No** (☐ Me ☐ Family)	Females: Are/could you be pregnant?	☐ **Yes** ☐ **No** ☐ **Not Sure**
Hepatitis C	☐ **Yes** ☐ **No** (☐ Me ☐ Family)		
Osteoporosis	☐ **Yes** ☐ **No** (☐ Me ☐ Family)		

At this time, my personal health is: ☐Good ☐Fair ☐Poor If you checked "poor", please explain:

Are there any other health problems you would like us to know about? ☐Yes ☐No If yes, please specify:

MEDICATIONS - List any medications you are taking (or bring a copy of the list).

Medication	Physician Who Prescribed the Med	Phone # (if available)

SURGERY/PROCEDURE - List any previous surgeries (or bring a copy of the list).		MONTH/YEAR
1.		
2.		
3.		

ALLERGIES ☐Yes ☐No		REACTION
1.		
2.		
3.		
4.		

Do you have means (e.g., a system or tool) to share your health information with other doctors or providers (e.g., medications, allergies, surgeries, hospital/pharmacy preferences, etc.)? ☐Yes ☐No

Note to Patient: If you DO NOT, see options in your intake packet. If you DO , let us know if we can assist you.

ADVANCE DIRECTIVES

Do you have an Advance Directive you would like to provide to us? ☐Yes ☐No

(OFFICE USE ONLY) Patient provided a copy of their Advance Directive today? ☐Yes ☐No; will provide at next visit

If no, would you like information on Advance Directives? ☐Yes ☐No

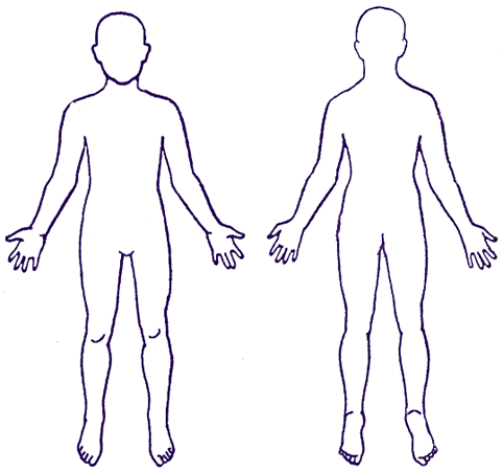
(OFFICE USE ONLY) Patient was provided information on Advance Directives ☐Yes ☐No

PAIN ASSESSMENT

Circle the Number that Describes Your Level of Pain:

0	No Pain
1 2 3	Low: No pain medications. Normal Levels of activity, except for heavy types.
4 5 6	Moderate: Regular use of pain medication and possibly muscle relaxants. Activity is very limited but functional for family and social roles.
7 8 9	High: Regular use of pain, and inflammatory and muscle relaxant medication. Activity limited to necessary self-care
10	Emergency Situation/Unbearable Pain

Shade in areas where you have pain, numbness or tingling.



Describe your pain (Check all that apply):

_____No Pain _____Shooting _____Aching
_____Throbbing _____Dull _____Sharp
_____Burning

What makes your pain better?

What makes it worse?

Patient Label

PRIOR LEVEL OF FUNCTION

Are you unable to perform any of the activities or do you need assistance with any of the below? (Check all that apply.)

Walking (☐ Need Help ☐ Unable)	Lifting (☐ Need Help ☐ Unable)	Bathing (☐ Need Help ☐ Unable)
Running (☐ Need Help ☐ Unable)	Carrying (☐ Need Help ☐ Unable)	Grooming (☐ Need Help ☐ Unable)
Stairs (☐ Need Help ☐ Unable)	Pushing (☐ Need Help ☐ Unable)	Dressing (☐ Need Help ☐ Unable)
Balance (☐ Need Help ☐ Unable)	Pulling (☐ Need Help ☐ Unable)	House Chores (☐ Need Help ☐ Unable)
Bending (☐ Need Help ☐ Unable)	Overhead Tasks (☐ Need Help ☐ Unable)	Driving (☐ Need Help ☐ Unable)
Squatting (☐ Need Help ☐ Unable)	Writing (☐ Need Help ☐ Unable)	Yard Work (☐ Need Help ☐ Unable)
Sitting (☐ Need Help ☐ Unable)	Turning a key (☐ Need Help ☐ Unable)	Meal Prep (☐ Need Help ☐ Unable)
Standing (☐ Need Help ☐ Unable)	Opening a jar (☐ Need Help ☐ Unable)	Other(s) (please specify):

What hobbies/leisure/recreational activities do you typically enjoy?

Does your current problem affect your ability to enjoy these activities?

Does your current problem affect your ability to participate in previous roles and responsibilities (e.g., work, school, social activities, parenting, care-giving, etc.)? ☐ NA, it doesn't ☐ Yes, it does (please specify):

EQUIPMENT: What equipment do you currently use or need to participate in therapy?

☐ Glasses/Contact Lenses	☐ Cane	☐ Prosthesis
☐ Hearing Aid	☐ Walker	☐ Orthotics
☐ Communication Device	☐ Wheelchair	☐ Other (specify):
☐ Splint	☐ Crutches	☐ Other (specify):

LIFESTYLE/EDUCATION (Check all that apply)

Home: ☐Single level ☐Split Level ☐ Multi-Story ☐Apt./Condo/Townhouse ☐Mobile/trailer
☐Other (specify): # of stairs to main living space:

Marital Status: ☐Single ☐Married ☐Widowed

Children (how many under 21): Ages:

Live with: ☐Spouse/ Significant Other ☐Grown Children ☐Friend(s) ☐Alone ☐Caregiver
☐Assisted Living ☐Long-Term Care Facility ☐Other (specify):

Highest level of education: ☐ Grade: _____ ☐ High School ☐ Technical/College/University

How do you learn best? ☐Reading ☐Listening ☐Demonstration ☐Pictures

Do you have any learning difficulties or barriers? ☐Yes ☐No Please specify:

My preferred language is: ☐ English ☐ Other (please specify):

Do you have any special cultural, religious, or spiritual practices/preferences that you would like us to be aware of/follow?

☐No ☐Yes If yes, please specify:

Patient Label

Is there any education or information you would like from STARS? ☐Yes ☐No

If yes, please specify:

Work Status: ☐Full Time ☐Part Time ☐Unemployed ☐Medical Leave ☐Retired

Occupation (please specify):

Title:

Responsibilities:

Please check any concerns you have in the left hand column (white column) below. Ignore the grey columns as they are for office use only.

CONCERNS **Please Check all that apply:**	**(FOR OFFICE USE ONLY) DOI: _____**		
	Patient encouraged to follow-up with PCP or Other Provider	Community resource info offered/provided	NA or Additional follow-up beyond treatment is not necessary
☐Recent falls/fear of falling	☐	☐	☐
☐Nutritional concerns	☐	☐	☐
☐Significant unexplained weight change	☐	☐	☐
☐Swallowing concerns	☐	☐	☐
☐Vocational concerns	☐	☐	☐
☐Health concerns	☐	☐	☐
☐Depression	☐	☐	☐
☐Anxiety	☐	☐	☐
☐Safety	☐	☐	☐
☐Other (specified above)	☐	☐	☐

Patient/Guardian Signature	**Date**	**Time**
Therapist Signature/Credentials	**Date**	**Time**
Interpreted by (if applicable)	**Date**	**Time**

Patient Label