Lovelace UNM Rehabilitation Hospital
505 Elm Street NE
Albuquerque, NM 87102

OP THERAPY SERVICES MEDICAL INFORMATION UPDATE
MEDS0018 (Rev 12/08/16)

The condition for which I am seeking therapy today: ______________________
Your family doctor/primary care physician (if different): ______________________
Describe the condition for which you are seeking therapy. Include how and when the condition began:
____
What makes the condition better? ______________________ Worse? ______________________
Have you had surgery for this condition? ❑ No ❑ Yes Procedure: ______________________
Have you been hospitalized for this condition? ❑ No ❑ Yes Date: ______________________
Special tests (MRI, CT scan, Bone Scan, X-rays, Nerve Tests): ______________________
Other interventions you have received for this condition? ______________________
What goals do you hope to accomplish in therapy ______________________
Does your past medical history include ❑ Dizziness/vertigo ❑ Swallowing problems ❑ Learning Problems
Please list any allergies: ______________________

❑ I will bring in a list of medications with prescribing physician's name and phone number upon next scheduled visit.
❑ Separate list attached, or Complete below:

Name of Medication	Dosage	Frequency	Prescribing Physician	Physician Phone #

Employment Status:
❑ Yes Occupation: ______________________ ❑ No Last date of employment ______________
Hours per week: ______________ Any Restrictions: ______________________
Work Duties (check all that apply)
❑ Sit ❑ Bend ❑ Carry ❑ Stand ❑ Squat ❑ Pull ❑ Walk ❑ Reach ❑ Push ❑ Other: ______________
❑ Lift How often to you lift? ______________________ How much do you lift? ______________________

Home information
Do you live in a: ❑ House ❑ Apartment ❑ Mobile Home ❑ Assisted Living ❑ Other: ______________
Number of stairs: __________ Inside __________ Outside Ramps: ❑ Yes ❑ No
Do you live ❑ Alone ❑ With family/friends Whom? ______________________
Please describe any help you receive in your home ______________________
Please list any equipment in your home to assist you (canes, walkers, wheelchairs, tub bench, raised toilet seat, braces, splints, etc.) ______________________
Do you drive yourself to appointments/activities? ❑ Yes ❑ No
Do you foresee any barriers in attending therapy? ❑ Transportation ❑ Languages ❑ Visual/Cognitive Impairment(s) ❑ Work/Child Care ❑ N/A ❑ Other: ______________________
Is there anything else you would like us to know? ______________________
❑ This information was reviewed with me, assistance was offered, as indicated.
Date: ______________ Time: __________ Patient Signature ______________________
Date: ______________ Time: __________ Reviewing Therapist Signature ______________________