**Patient Assessment / Evaluation (Print Full Document)**

1. **General Information.**
2. **Chief Complaints with Chorological Duration.**
3. **History of Present Illness.**
4. **Past Medical History**
5. **Prior Functional Status.**
6. **Other Medical & Social History.**
7. **Clinical Examination**
8. **Investigation.**
9. **Prognosis.**
10. **Diagnosis With ICD -10 Code**
11. **Clinical Management with Patient Education.**
12. **E-Prescription.**

**Initial Print Document**

1. **Diagnosis With ICD -10 Code**
2. **E-Prescription.**

**Revisit Details (All verify from Previous report & and it will be editable)**

**RIMS INDIA PVT.LTD**

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| **Name:** |  | **Referral:** |  | **Date:** |  |

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| **General Information :** | | | | | | |
| **Date of Birth:** |  | Age: |  | Sex: | Male | Female |
| **Race / Ethnicity:** | Asian | Black | Pacific Islander | Latino | | |
| Native American | White | Hispanic |  | | |
| **Language:** | Speaks English | | Interpreter needed | | | |
| Speaks & Understand | |  | | | |
| **Highest Level of Education:** | Grade School | Technical School | Some College | Master’s Degree | | |
| High School | Trade School | College Graduate |  | | |
| **Hand / Foot Dominance:** | N/A | Ambidexterous | Left | Right | | |

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| **Social History & Living Environment:** | | | | | | |
| **Referral Source:** |  | | | | | |
| **Where do you live?** | Private Home | Rented Home | | Extended Care | Hospice | |
| Apartment | Border | | Homeless |  | |
| **With whom do you live?** | Alone | Relative(s) | | Friend(s) | Child or Children | |
| Spouse | Parents(s) | | Group setting |  | |
| Partner | Brother(s) | | Sister(s) |  | |
| **Does your home have?** | One level | Two level | | Multi – level | Stairs, no railing | |
| Ramps | Elevation | | Elevators | Stairs, railing | |
| Uneven terrain | Any Obstacles (list): | | | | |
| **How many steps:** | No.Steps outside the home: | |  | No.Steps inside the home: | |  |
| **Do you use:** | Forearm Crutches | Axillary Crutches | | Straight Cane | Walker | |
| Manual Wheelchair | Quad Cane | | Two Canes | Rolling Walker | |
| Motor Wheelchair | Glasses | | Hearing aid | Others: | |
| **Cultural/Religious:** | | | | | | |
| Any cultural or religious beliefs or wishes that might affect care? | | | | | | |

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| **Social/Health Habits:** | | | | | | | | |
| **Do you Smoke Tobacco:** | No | | | Occasionally | Socially | Daily | | Heavily |
| **Do you Drink Alcohol:** | No | | | Occasionally | Socially | Daily | | Heavily |
| **Exercise:** | No | | Yes | If yes how many times per week: | | | How many minutes per day: | |
| **(Beyond normal daily activities & Chores)?** | | Describe exercise or activity: | | | | | | |

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| **Employment/Work (Job/School/Play):** | | | | | | |
| **Work status:** | Unemployed | Work full-time | | Work light-duty | | Student |
| Homemaker | Work part-time | | Disabled | | Retired |
| **Occupation:** |  | | | | | |
| **Your work involves:**  **(Check all that apply)** | Prolonged Standing | | Working with bent neck | | Lifting light object | |
| Prolonged Sitting | | Frequent typing | | Lifting heavy object | |
| Prolonged Walking | | Repetitive overhead work | | Carrying light object | |
| Prolonged Driving | | Excessive reaching | | Carrying heavy object | |
| Prolonged forward bending | | Frequent hand grasping | | Repetitive pushing/pulling | |
| Exposure to | | Climbing ladders | | Repetitive arm motions | |
| Exposure to | | Excessive stair climbing | | Repetitive foot motions | |
| Other: | | | | | |

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| **General Health Status:** | | | | | |
| **Please rate your health:** | Excellent | Good | Fair | Poor | Don’t Know |
| **Major life changes (past year)** | None | Death in family | New job | Divorce | New Baby |

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| **Family history – Please check if anyone in your family has or had any or the following:** | | | | |
| Heart Disease | High Blood Pressure | Cancer | Psychological | Pulmonary/Lung Disease |
| Diabetes | Arthritis | Stroke | Osteoporosis |  |

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| **Past medical history -** **Please check if anyone in your family has or had any or the following:** | | | |
| No past medical history | Diabetes | Genetic Disease | Pacemaker |
| AIDS | Emphysema | Kidney Disease | Parkinson’s Disease |
| Asthma | Epilepsy/Seizures | Liver Disease | Prostate Disease |
| Arthritis | Glaucoma | Low Blood Pressure | Skin Disorder |
| Blood Disorder | Heart Attack | Lung Disorder | Stroke |
| Broken Bones | Heart Disease | Lyme’s Disease | Thyroid Disorder |
| Circulation Problems | Hepatitis | Macular Degeneration | Ulcers (Stomach) |
| Cancer | Head Injury | Multiple Sclerosis | Repeated Infections |
| Cystic Fibrosis | High Blood Pressure | Osteoporosis |  |
| Depression | High Cholesterol | Muscular Dystrophy |  |

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| **Past medical history – for women only:** | | | | | |
| **Pelvic Inflammatory Disease** | Yes | No | **Trouble with Period** | Yes | No |
| **Complicated Pregnancies** | Yes | No | **Pregnant** | Yes | No |
| **Endometriosis** | Yes | No |  | Yes | No |

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| **Surgical History – Please list any surgeries you had, and if known include dates:** | | | |
| No surgeries to date | | | |
| 1. | Date: | 2. | Date: |
| 3. | Date: | 4. | Date: |

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| **Past Symptoms History Checklist – within the past year, have you had any of the following (Check all that apply):** | | | |
| **No Symptoms in Past Year** | Difficulty Walking | Joint Pain or Swelling | Tremors |
| **Bowel Problems** | Dizziness/Blackouts | Loss of Appetite | Urinary Problems |
| **Chest Pain** | Excessive Sweating | Loss of Balance | Vision Problems |
| **Cough (persistent)** | Fatigue | Nausea/vomiting | Weakness in arm/legs |
| **Decreased co-ordination** | Headaches | Numbness in arms/legs | Weight gain(Unexplained) |
| **Difficulty Sleeping** | Hearing Problems | Pain at Night | Weight loss(Unexplained) |
| **Difficulty Swallowing** | Heart Palpitations | Shortness Of Breath |  |

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| **Diagnostic Test/Measures - within the past year, have you had any of the following (Check all that apply):** | | | |
| **No Diagnostic Testing** | Bronchoscopy | EMG/Nerve Conduction | Stool Test |
| **Angiogram** | CT scan | Mammogram | Stress Test |
| **Arthroscopy** | Ultrasound | MRI | Urine Test |
| **Biopsy** | Echocardiogram | Pap smear | X - Ray |
| **Blood Test** | EEG | Pulmonary function Test |  |
| **Bone Scan** | EKG | Spinal Tap |  |

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| **Medications & Allergies – please check or list all medications or allergies:** | | | | |
| **Non - Prescription** | No Medications | Decongestant | | Motrin |
| Advil/Alleve | Excedrin | | Vitamins/minerals |
| Antihistamines | Herbal Supplements | | Tylenol |
| Asprin | Ibuprophen/Naproxen | |  |
| **Prescription:** | No Medications | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Allergies:** | No Known Allergies to date | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **Functional Status/ Activity level:** | | | | | | | | |
| **Current Functional Satus:** | | | | | | | | |
| **Difficulty with locomotion/movement Such as:** | Bed Mobility | | Transfers(such as bed to chair, from bed to commode/toilet)) | | On ramps | | | |
| On uneven surfaces | | | |
| Gait (Walking) | | On level surfaces | | On stairs | | | |
| **Difficulty with self-care activities such as:** | Bathing | | Dressing | | Toileting | | | |
| **Difficulty with home management such as:** | Household Chores | Shopping | | Driving/Transportation | | | Care of Dependents | |
| **Difficulty with community and work activities such as:** | Work | School | | Recreation | | Sport | Play Activity | |
| **Prior Functional Status (Your status prior to the date of onset/injury)** | | | | | | | | |
| Prior to the current injury condition, were you pain free without any difficulty with locomotion/movement, self-care activities, home, community and work activities………………….. | | | | | | | | Yes |
| No |

If No, Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Condition(s)/Chief Complaints:

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| What Makes Your Symptoms Worse? | | |  | | | | |
| What Makes Your Symptoms Better? | | |  | | | | |
| What is Your Goal For Physical Therapy? | | |  | | | | |
| Are You Seeing Anyone Else For Your Problems? | | | Yes | No | | If Yes, Please Check all that Apply | |
| Acupuncturist | Cardiologist | Chiropractor | | | Neurologist | | Podiatrist |
| Family Doctor | Orthopedist | Massage Therapist | | | Rheumatologist | |  |