

Adult Initial History Assessment

(All sections need to be completed by patient/significant other. Use black ink. Check yes or no each question.)

General Information

1. What is your reason for this visit? _____
2. Who is your doctor? _____ Name your other doctors: _____
3. Who is your retail pharmacy? _____ Phone Number: _____
4. Do you have any special needs/requests for you or your family? Yes No
(For example: use of blood products, limited visitors, religious/cultural practices, emotional issues or other concerns.)
If yes, how may we assist you? _____
5. Do you have any problems reading, hearing, speaking, or writing English? Yes No
Primary Language? _____
Will you need an interpreter? Yes No If yes, do you have a preferred interpreter? Yes No
Person / Service _____ Phone # _____
Hospital interpreter initiated? Yes No
Person / Service _____ Phone # _____
Staff initiating signature _____ Date _____
 Interpreter Refused

Discharge Planning (Refer to Medical Resource Management)

1. You live in a House Apartment Nursing Home _____ Assisted Living _____
 Other _____
2. Do you plan to return to your home after you are discharged? Yes No
If no, where do you plan to go? _____
3. Do you live alone? Yes No
4. Can you care for yourself? Yes No
If not, do you have family/friends available and willing to help provide your care? Yes No R
Who will be the responsible adult to help you make decisions regarding your care and assist you after discharge?
Name/Relationship: _____ Phone Number: _____
5. **Have you recently missed taking your medications or treatments because you are unable to pay for them?** Yes R No
Describe: _____

Screening Questions (Refer to Medical Resource Management)

1. **Do you use any outside help or community service at home?** Yes R No R
If yes, which ones: Adult Care Home Care Hospice Other _____
Name of agency(ies) providing service _____
2. Do you feel safe in your living environment? Yes No R
3. In the last year, has anyone forced you to have sexual activity? Yes R No
4. Within the last year, have you been hit, slapped, kicked, or harmed by your intimate partner or Caregiver? Yes R No
5. Are you ever afraid of your partner or caregiver? Yes R No
6. Are the persons in your life that consistently control your actions or put you down? Yes No
7. Do you smoke currently? Yes No
8. Have you ever smoked? Yes No
Amount/day _____ Years _____ When last smoked? _____
9. Other tobacco use? Yes No
Type _____ Last used _____
10. Use of recreational drugs? Yes No
Type _____ Last used _____
11. Alcohol intake? Yes No
Amt/day _____ Years _____ Last used? _____



Adult Initial History Assessment

Senses	Y	N	Bones/Joints	Y	N	Nervous/Mental	Y	N
Hard of hearing/Deaf	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/fainting/passing out	<input type="checkbox"/>	<input type="checkbox"/>
Blind/Poor vision	<input type="checkbox"/>	<input type="checkbox"/>	Gout/bursitis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke / TIA _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> right eye <input type="checkbox"/> left eye			Broken Bones/Fractures	<input type="checkbox"/>	<input type="checkbox"/>	When? _____		
Visual Implants	<input type="checkbox"/>	<input type="checkbox"/>	Where? _____			Paralysis: Where? _____	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma/Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty speaking	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Where? _____		
Difficulty reading	<input type="checkbox"/>	<input type="checkbox"/>	Total Joint	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
						Last episode _____		
Heart Lung	Y	N	Blood	Y	N	Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell trait or disease	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy/Other	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain/angina	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Specify _____		
When? _____			Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Cord Injury	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack. When? _____	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Heart Cath/Stent. When? _____	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	How often? _____		
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots/Aneurysms	<input type="checkbox"/>	<input type="checkbox"/>	Other brain, nervous problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Where? _____			Type _____		
Abnormal heart rhythm	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Mental illness	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	When? _____			Type _____		
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Reaction? _____			Depression	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker: type _____	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Reproductive	Y	N
Internal Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>				Could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Date of last EKG _____			Liver/GI	Y	N	Using birth control? _____	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea/Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Date of last period _____		
COPD/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Last Bowel movement _____			Breast Feeding	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Colitis/Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Disease		
Date of last attack _____			Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	(Refer to Infection Control)	Y	N
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia/Gastric Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis: type _____	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough/bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice/Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	HIV positive	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	MRSA	<input type="checkbox"/>	<input type="checkbox"/>
Other Lung Diseases:	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder disease/stones	<input type="checkbox"/>	<input type="checkbox"/>	VRE	<input type="checkbox"/>	<input type="checkbox"/>
Type: _____			Other stomach/Intestinal	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>
Bloody Sputum	<input type="checkbox"/>	<input type="checkbox"/>	problems, type _____			Exposure to TB	<input type="checkbox"/>	<input type="checkbox"/>
Deep vein thrombosis?	<input type="checkbox"/>	<input type="checkbox"/>	Otosomy, type _____	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to any infections /		
Pulmonary Embolus?	<input type="checkbox"/>	<input type="checkbox"/>	Feeding tube, type _____	<input type="checkbox"/>	<input type="checkbox"/>	contagious diseases		
Recent respiratory infections/ productive cough/	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	Y	N	within last 2 weeks.	<input type="checkbox"/>	<input type="checkbox"/>
Can you walk up one flight of stairs without stopping?	<input type="checkbox"/>	<input type="checkbox"/>	Kidney failure/insufficiencies	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what? _____		
Sleep Apnea?	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease/stones	<input type="checkbox"/>	<input type="checkbox"/>	Current infections	<input type="checkbox"/>	<input type="checkbox"/>
			Dialysis: type _____	<input type="checkbox"/>	<input type="checkbox"/>	Where? _____		
			Date of last dialysis _____			Cuts/sores/rashes	<input type="checkbox"/>	<input type="checkbox"/>
			Shunt: type _____	<input type="checkbox"/>	<input type="checkbox"/>	Where?		
			Bladder infections	<input type="checkbox"/>	<input type="checkbox"/>	Vaccines	Y	N
			Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	Flu (influenza) within a year	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	Y	N	Incontinence/Frequency	<input type="checkbox"/>	<input type="checkbox"/>	Tetnus (within last 10 yrs.)	<input type="checkbox"/>	<input type="checkbox"/>
History of Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Foley Catheter	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
When? _____						Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Where? _____			Endocrine	Y	N			
Have you ever received treatment for Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: type _____	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, what type? <input type="checkbox"/> Surgery			Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation			Received cortisone, steroids, etc. in last year	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Other _____			Lupus	<input type="checkbox"/>	<input type="checkbox"/>			
Family history _____								



Adult Initial History Assessment

Instruction: Check "yes" or "no" and answer each question.

Dental	Y	N
Check if you have:		
Dentures	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Caps <input type="checkbox"/> Crowns <input type="checkbox"/> Bridges	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Loose or chipped teeth	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Missing teeth	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> partial <input type="checkbox"/> upper <input type="checkbox"/> lower	<input type="checkbox"/>	<input type="checkbox"/>

Airway / Anesthesia	Y	N
Problems / pain moving head/neck/jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Does lying flat cause you breathing difficulty?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or any blood relative had problems with anesthesia? If yes, who: _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you use CPAP for sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>

Spiritual (Refer to Chaplaincy)	Y	N
Do you have any religious or cultural beliefs or practices that would impact your medical treatment? If yes, specify _____	<input type="checkbox"/>	<input type="checkbox"/>
Other than related to this hospitalization, have you experienced any recent changes, stresses or losses? If yes, specify _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any concerns you would like to discuss with our hospital chaplain?	<input type="checkbox"/>	<input type="checkbox"/>

Medical Equipment	Y	N
Circle if you brought them with you:		
Contact Lenses / Glasses	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Limb: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aid <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>
Artificial eyes <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>
Cane / Walker / Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>
Home Breathing Equipment: _____	<input type="checkbox"/>	<input type="checkbox"/>
Oxygen and CPAP	<input type="checkbox"/>	<input type="checkbox"/>
Infusion Pump: type _____	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
What company(ies) provide you with the above items? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a Central Line / Infusion Port	<input type="checkbox"/>	<input type="checkbox"/>
Type: _____		

Allergies / Reactions	<input type="checkbox"/> None known <input type="checkbox"/> Latex

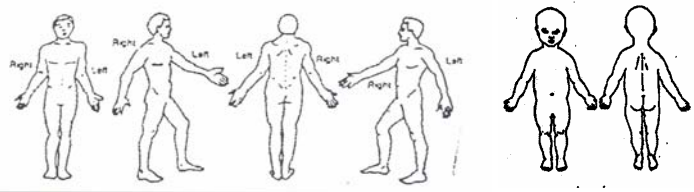
Current Medications: Include OTC, Herbal, O2, Inhalers None

Medication Name	Indication (if pt. knows)	Dose	Frequency	Last Dose Taken

Nutrition (Refer to Nutrition Services)	Y	N
Without trying, have you lost ten pounds or more in the past six months?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any physical problems that make it hard to eat? (i.e., chewing, swallowing, diarrhea, vomiting, mouth sores)	<input type="checkbox"/>	<input type="checkbox"/>
Do you have poor healing wounds?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a poor appetite?	<input type="checkbox"/>	<input type="checkbox"/>
Do you follow a special diet at home?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, explain: _____		
Do you desire education on the diet your doctor has ordered?	<input type="checkbox"/>	<input type="checkbox"/>

Family History (Blood Relatives)	
(Check all that apply and give relationship)	
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Kidney/Urinary _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> (type) _____	
<input type="checkbox"/> Heart _____	<input type="checkbox"/> Bleeding Problems _____
<input type="checkbox"/> Lung _____	<input type="checkbox"/> Liver/Stomach _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Sickle Cell Trait / Disease _____
<input type="checkbox"/> TB _____	<input type="checkbox"/> Mental/Emotional Problems _____
<input type="checkbox"/> Hepatitis _____	
<input type="checkbox"/> Seizures _____	

Hospitalizations	
List major illnesses / surgeries / procedures:	Date



Locate area and shape of any wound, scars, trauma, tattoos, or piercings in appropriate place on the figures (what it is, size, color, discharge, odor, inflammation, etc.)

1. _____	
2. _____	
3. _____	
4. _____	
5. _____	



Adult Initial History Assessment

STAFF USE ONLY: Vital Signs T _____ P _____ R _____ BP _____ Ht. _____ Wt. _____

**THE NURSE / THERAPIST WILL ASSIST YOU IN COMPLETION OF THE FOLLOWING INFORMATION:
PAIN ASSESSMENT**



Scale: 0-10 Faces 0 2 4 6 8 10

1. When you experience pain what is your acceptable level? Score _____ Are you experiencing acute pain? Yes No
 Identify location _____ Score via scale _____ Describe: Quality _____
 Onset / duration _____ What aggravates _____ What relieves _____
 Do you experience chronic pain? Yes No
 Identify location _____ Score via scale _____
 Describe: Quality _____ Onset / duration _____ What aggravates _____
 What relieves _____

OUTPATINET REHABILITAION – to be completed in Outpatient Rehab only (excluding wound care patients)

1. What are your goals for rehabilitation? (Check all that apply.)
 Return to work Return to sports activities Care for family
 Other _____
2. Have you ever received Physical, Occupational or Speech Therapy before? Yes No
 If yes, where? _____
3. Are you presently working? (Check all that apply.) Yes No
 Full-time Part-time Retired Who is your employer? _____
 If you are not working, is it due to: Medical Leave Disability Personal Choice
 _____ (Physician Signature)

Functional Ability Screen (for age)				
Independent	Acute Change < 6 Months	Chronic Change	Limited pain	Refer inpt. * items to Rehab for screen or Md for Rehab order
	R*			Dressing/Toileting/ Bathing (OT)
	R*			Feeding (Speech)
	R*			Swallowing (Speech)
	R*			Speech (Speech)
	R*			Hearing (Audiology)
	R*			Getting in/out of bed/chair (PT)
	R*			Walking (PT)
Safety Risk <input type="checkbox"/> None or N/A				
<input type="checkbox"/>	Low	Physical risk factors-impaired vision / hearing, TIA, seizures, frequency or impaired bowel / bladder control		
<input type="checkbox"/>	Mod	<ul style="list-style-type: none"> • Previous Fall • Impaired decision-making without physical risk factors 		
<input type="checkbox"/>	High	<ul style="list-style-type: none"> • Impaired decision-making with physical risk factors • Behavior compromising treatment • Physically aggressive or verbally abusive • Threatening harm to self or others 		

Patient/Family Signature: _____
 (Give relationship if not patient): _____
 Information incomplete due to: _____
 Staff Signature/Date: _____
 Staff Signature/ Date/Time: _____
 Reviewed/Completed: _____
 Patient/Family

Staff Use Only – Referrals made to the following			
	Date	Initials	Initials
Medication Resource Mgt.	_____	_____	Chaplaincy _____
Infection Control	_____	_____	Primary _____
Nutrition	_____	_____	Care MD _____
Rehabilitation	_____	_____	Interpreter _____
If referral(s) not needed at this time, circle discipline and state reason _____			
Admission handbook referral: _____			

