St. John Health System
Medical Excellence • Compassionate Care

12
1SJ76

OUTPATIENT REHABILITATION
PATIENT SELF-ASSESSMENT

PATIENT NAME/NAME OF PERSON COMPLETING FORM	AGE	SEX	DATE

ONSET OF INJURY/ PAIN	DATE OF SURGERY	PHYSICIAN	DATE OF NEXT DR.'S APPOINTMENT

OCCUPATION	ARE YOU WORKING NOW? ☐ Yes ☐ No

HOW AND WHEN DID YOUR SYMPTOMS FIRST START?

WHAT DOES YOUR PAIN/INJURY PREVENT YOU FROM DOING?

WHAT WOULD YOU LIKE TO ACHIEVE FROM THERAPY? WHAT ARE YOUR GOALS?

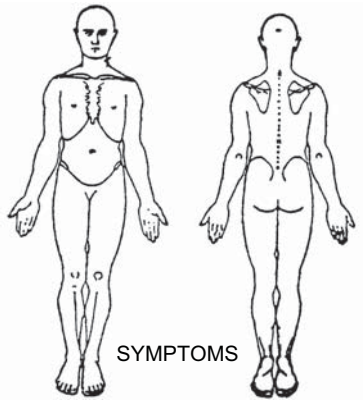
PRESENT SYMPTOMS/LOCATION SYMPTOMS

Symptom	Location
☐ Pain	
☐ Numbness, Tingling, Burning	
☐ Stiffness	
☐ Headaches	
☐ Weakness	
☐ Other (specify)	

☐ Dizziness ☐ Nausea ☐ Ringing in ears
☐ Difficulty swallowing/chewing ☐ Difficulty breathing
☐ Double vision ☐ Blurred vision

Indicate area(s) of symptoms on drawing.

X = pain
/// = numb/tingling
***** = other



PAIN RATINGS (USE 0 - 10 SCALE)

Please rate pain on the scale below:

0 = No pain

10 = Worst possible pain

BODY PART	At Present	At Worst	At Best
	10	10	10
	10	10	10
	10	10	10

WHAT INCREASES YOUR PAIN

WHAT DECREASES YOUR PAIN

DO YOU HAVE SPECIFIC DIETARY NEEDS DUE TO A MEDICAL CONDITION?
☐ Yes ☐ No

DO YOU HAVE SPECIFIC SOCIAL, SPIRITUAL, OR CULTURAL NEEDS THAT WE NEED TO ADDRESS?
☐ Yes ☐ No

DIAGNOSTIC TESTS PERFORMED

☐ MRI ☐ X-rays ☐ Myelogram ☐ CT Scan

RESULTS

PREVIOUS THERAPY

FALL RISK

Have you recently fallen?	☐ Yes	☐ No
Are you afraid of falling?	☐ Yes	☐ No
Do you feel unsteady on your feet?	☐ Yes	☐ No
Do you have a leg problem that affects walking?	☐ Yes	☐ No
Do you use a cane, walker or crutches?	☐ Yes	☐ No
Do you have memory/cognitive difficulties?	☐ Yes	☐ No
Do you take medication that affects your ability to walk?	☐ Yes	☐ No
Do you have vision problems?	☐ Yes	☐ No

REVIEWED BY	THERAPIST'S LICENSE NO.

CONFIDENTIAL INFORMATION

St. John Health System

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ADMISSIONS INFORMATION

Complete front and back of form *– PLEASE PRINT LEGIBLY*

DO NOT REMOVE FROM CHART

CONFIDENTIAL INFORMATION

Have you ever been a patient at St. John Medical Center? ☐ Yes ☐ No

Is this visit the result of an accidental injury? ☐ Yes ☐ No

Is this injury work related? ☐ Yes ☐ No

Type of accident, if not work related: ☐ Automobile ☐ Other _____

Date of accident/injury: _____

PATIENT INFORMATION

Last Name	First Name (legal)	Middle Initial	Maiden/Previous Name
Address: Street	City	State	Zip Code
Phone No.	Date of Birth	SSN	Sex ☐ Male ☐ Female
Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Legally separated		Born in the United States? ☐ Yes ☐ No	
Religion	Name of Church	Race	Language
Patient's Employer's Name		☐ Full Time ☐ Part Time ☐ Retired: date _____	
Patient's Employer's Address			Business Phone No.
Spouse: Last Name	First Name	Date of Birth	SSN
Spouse's Employer	Business Phone No.	☐ Full Time ☐ Part Time ☐ Retired: date _____	

RESPONSIBLE PARTY/ EMERGENCY CONTACT

Responsible Party	SSN	Date of Birth	Employer
Address	Home Phone No.		Business Phone No.
Emergency Contact		Relationship	
Home Phone No.	Cell Phone No.	Business Phone No.	

– Turn over and complete other side –

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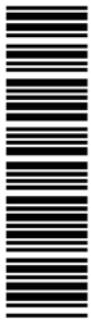
ADMISSIONS INFORMATION

DO NOT REMOVE FROM CHART



PRIMARY INSURANCE

Primary Insurance Company Name	ID or Policy Number	Group Number
Is your coverage with ***your*** current employer? ☐ Yes ☐ No	Is your coverage with your ***spouse's*** employer? ☐ Yes ☐ No	
Policy Holder's Name	SSN	Date of Birth
Employer's Name (if not patient's or spouse's employer)		
Send Claims to (address on back of card)		

SECONDARY INSURANCE

Secondary Insurance (if any)	ID or Policy Number	Group Number
Is this coverage with your current employer? ☐ Yes ☐ No	Is your coverage with your ***spouse's*** employer? ☐ Yes ☐ No	
Policy Holder's Name	SSN	Date of Birth
Employer's Name (If not patient's or spouse's employer)		
Send Claims to (address on back of card)		

COBRA

Are you covered under either Primary or Secondary Insurance through COBRA? ☐ Yes ☐ No		Name of Employer
Patient? ☐ Yes ☐ No	Other ☐ Husband ☐ Wife	☐ Mother ☐ Father ☐ Other _____

HOSPITAL USE ONLY

OUTPATIENT: LOCATION	INPATIENT: LOCATION	ADMIT DATE
REFERRING PHYSICIAN	ADMITTING PHYSICIAN	PCP
DIAGNOSIS/ADMIT REASON		

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St. John Medical Center
1923 S. Utica Ave. • Tulsa, OK 74104

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OUTPATIENT SERVICES
AMBULATORY SUMMARY

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DIAGNOSIS/CONDITIONS

- ☐ Cancer
- ☐ Diabetes
- ☐ Cardiovascular Disease
  - ☐ Heart Attack
  - ☐ Congestive Heart Failure
  - ☐ High Blood Pressure
  - ☐ Stroke
  - ☐ Pacemaker/Defibrillator
  - ☐ Peripheral Vascular Disease
- ☐ Respiratory Disease
  - ☐ COPD
  - ☐ Asthma
  - ☐ Positive TB Test
  - ☐ Pulmonary Fibrosis
- ☐ Seizures
- ☐ Concussion
- ☐ Clotting Disorder
- ☐ Digestive Disease
  - ☐ Colitis
  - ☐ Stomach Ulcers
  - ☐ Hiatal Hernia
  - ☐ Reflux (GERD)
- ☐ Hepatitis
- ☐ Genital/Urinary
  - ☐ Liver Disease
  - ☐ Kidney Disease
  - ☐ Bladder/Bowel Incontinence
  - ☐ Male/Female Issues
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Thyroid Disease
- ☐ Depression/Anxiety
- ☐ Brain Injury
- ☐ Osteoporosis
- ☐ Dementia
- ☐ HIV
- ☐ Sleep Apnea
- ☐ Restless Leg Syndrome
- ☐ Orthopedic Conditions
- ☐ Neurological Condition
- ☐ VRE ☐ MRSA ☐ C-diff
- ☐ _____
- ☐ _____
- ☐ None at this time Date _____

COMMENTS

SURGERIES/PROCEDURES

*Check **IF** you have had any of the following, and list date of surgery/procedure.*

	DATE
☐ Abdominal	
☐ Back/Spinal	
☐ Breast	
☐ Cataract	
☐ Female/Male	
☐ Heart	
☐ Joint	
☐ Kidney	
☐ Lung	
☐ Neck	
☐ Orthopedic	
☐ Other:	
☐ None at this time	

List specifics relating to surgeries/ procedures checked

LEARNING BARRIERS ASSESSMENT

PREFERED LANGUAGE TO DISCUSS HEALTH CARE NEEDS

Do you prefer to learn with

- ☐ Verbal Instructions
- ☐ Pictures
- ☐ Written Instructions
- ☐ Hands-on

Learning barriers

- ☐ None
- ☐ Religious
- ☐ Unreceptive
- ☐ Cognitive
- ☐ Communication
- ☐ Physical Disabilities
- ☐ Fatigue/Pain
- ☐ Emotional
- ☐ Vision Deficit
- ☐ Cultural
- ☐ Hearing Deficit

Explain any barriers

_____

_____

UPDATES/CHANGES

*Complete this section **ONLY** if there has been a change since the last visit.*

DATE	TIME	EXPLAIN CHANGE
INITIAL		
DATE	TIME	EXPLAIN CHANGE
INITIAL		
DATE	TIME	EXPLAIN CHANGE
INITIAL		

COMMENTS

This section to be filled out by nurse or clinician only

ADVANCE DIRECTIVES (AD)

Do you have an Advance Directive on file at SJMC? ☐ Yes ☐ No

If NOT, do you have an Advance Directive? ☐ Yes ☐ No

If NO, would you like the "Your Advance Directive for Health Care" booklet? ☐ Yes ☐ No

INFORMATION VERIFIED/UPDATED BY

NAME	INT	DATE	TIME	NAME	INT	DATE	TIME	NAME	INT	DATE	TIME
NAME	INT	DATE	TIME	NAME	INT	DATE	TIME	NAME	INT	DATE	TIME
NAME	INT	DATE	TIME	NAME	INT	DATE	TIME	NAME	INT	DATE	TIME

St. John Health System

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Name _____

DOB _____

MR # _____

OUTPATIENT SERVICES

MEDICATION RECONCILIATION RECORD

Med. Page _____ of _____

List below all of the patient's medications prior to admission including over the counter and alternative medications

DO NOT USE ABBREVIATIONS: U, IU, Q.D., Q.O.D., MS, MSO4, MgSO4

NEVER USE TRAILING ZERO, ALWAYS USE LEADING ZERO

ALLERGIES

☐ None

Shellfish	☐ Yes	☐ No	☐ Unknown
Latex Rubber	☐ Yes	☐ No	☐ Unknown
X-ray Dye	☐ Yes	☐ No	☐ Unknown

DATA SOURCE *(CHECK ALL THAT APPLY)*

☐ Patient ☐ Family ☐ Med. Container ☐ H & P ☐ Other _____

PATIENT'S PHARMACY NAME *(IF AVAILABLE)*

TELEPHONE

REASON UNABLE TO OBTAIN MEDICATION HISTORY

☐ No Home Medication

MEDICATION NAME (INCLUDING OVER THE COUNTER AND ALTERNATIVE MEDICATIONS) *Write Legibly*	REASON	*FOR OFFICE USE ONLY – Not required for minimal Med. use areas*						
		Dose	Route	Frequency	Date Last Taken	Date DC'd	New Med. Start Date	INT

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✱✱ *THIS FORM IS NOT AN ORDER – INFORMATION VERIFIED/UPDATED BY* ✱✱

CLINICIAN	INT	DATE	TIME	CLINICIAN	INT	DATE	TIME	CLINICIAN	INT	DATE	TIME
CLINICIAN	INT	DATE	TIME	CLINICIAN	INT	DATE	TIME	CLINICIAN	INT	DATE	TIME
CLINICIAN	INT	DATE	TIME	CLINICIAN	INT	DATE	TIME	CLINICIAN	INT	DATE	TIME