

Please return form to: Drake Center  
Attn: Sarah Sutliff  
151 W. Galbraith Rd.  
Cincinnati, Oh 45216  
Phone: (513) 418-2740  
Or Fax to: (513) 418-5838

# PATIENT DATA FORM



Date: \_\_\_\_\_

Signature of patient: \_\_\_\_\_

Print name \_\_\_\_\_

Signature of person filling out form (if not patient): \_\_\_\_\_

Phone number of patient or contact person: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_       Male       Female      I write with my     Right     Left hand.

How did you hear about our program?     Media (radio/TV)     Stroke Support Group     Article/Newspaper  
 Healthcare Professional     Friend/Relative     Other \_\_\_\_\_

## CHIEF COMPLAINT

What was the date of your stroke? \_\_\_\_\_

What particular problem(s) brings you to the doctor? \_\_\_\_\_

\_\_\_\_\_

## PAST MEDICAL HISTORY

Please list medical conditions, other than present illness and including sprains and fractures, for which you are (or have been) treated?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

Immediately after your stroke, how long did you receive Physical Therapy (PT)?

- None
- 1-3 months
- >9 months
- Eval only in the hospital
- 4-6 months
- Less than 1 month
- 7-9 months

Immediately after your stroke, how long did you receive Occupational Therapy (OT)?

- None
- 1-3 months
- >9 months
- Eval only in the hospital
- 4-6 months
- Less than 1 month
- 7-9 months

Immediately after your stroke, how long did you receive Speech Therapy (ST)?

- None
- 1-3 months
- >9 months
- Eval only in the hospital
- 4-6 months
- Less than 1 month
- 7-9 months

**PAST SURGICAL HISTORY**

Have you ever been operated upon? Yes \_\_\_\_\_ No \_\_\_\_\_  
Please list surgical procedures and dates:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**CURRENT MEDICATIONS**

	Name of Medication	Dose	Frequency
1.	_____		
2.	_____		
3.	_____		
4.	_____		
5.	_____		
6.	_____		
7.	_____		
8.	_____		
9.	_____		

Do you have allergies?  Yes  No If so, please list: \_\_\_\_\_

## **FAMILY HISTORY**

Does anyone related to you have (please circle):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Hypertension                                | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> High Cholesterol    |
| <input type="checkbox"/> Heart Disease                               | <input type="checkbox"/> Migraines                 | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Muscular Dystrophy                          | <input type="checkbox"/> Strokes                   | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Alzheimer's Disease                         | <input type="checkbox"/> Neuropathy                | <input type="checkbox"/> Thinking Problems   |
| <input type="checkbox"/> Multiple Sclerosis                          | <input type="checkbox"/> Cancer (name type): _____ |  |
| <input type="checkbox"/> Motor Neuron Disease (Lou Gehrig's Disease) | <input type="checkbox"/> Bowel/Bladder Control     |  |
| <input type="checkbox"/> Other Neurological Diseases: _____          |  |  |

Is your mother living? \_\_\_\_\_ If not, cause of death: \_\_\_\_\_

Is your father living? \_\_\_\_\_ If not, cause of death: \_\_\_\_\_

## **SOCIAL HISTORY**

Do you smoke?  Yes  No (Never)  No ( I quit) \_\_\_\_\_

If "yes", how many packs per day?  Less than one  One  Two  Three or more

Do you drink alcohol?  Yes  No (Never)  No ( I quit) \_\_\_\_\_

If "yes", amount per day? \_\_\_\_\_ drinks Amount per week \_\_\_\_\_ drinks

Have you ever been treated for alcohol dependence?  Yes  No (Never)

### **Employment Status**

Employed:  Yes  No (Never)

Nature of work: \_\_\_\_\_ Hours/week: \_\_\_\_\_

Unemployed:  Not seeking work  Seeking work  Unable to work

Retired – Previous Occupation:

Employment Goal:  Intend to return to work  Do not intend to return to work

## Living Status

- Marital Status:  Married  Separated  Divorced  
 Widowed  Single  Significant Other
- Living Arrangements:  Home  Apartment  Nursing Home  
 Assisted Living  Trailer  Homeless  
 Independent Living  Justice Center  Group Home
- Home Access:  One Floor  Two Floors  Number of floors: \_\_\_\_\_  
 Steps: # steps: \_\_\_\_\_  Railing  Elevator
- Living Situation:  Live Alone  Dependent Children  
 Live with Other: \_\_\_\_\_
- Driving Status:  Independent Driver  Dependent on Caregiver  Public Transportation
- Driving Goal:  Intends to return to Driving  Does not intend to return to driving
- Support available:  Family  Neighbor  Friend  
 Care Provider  Meals on Wheels  Other  
 Life Line Services  None
- Available support:  No support available  
 Limited support available: (please specify hours/days per week) \_\_\_\_\_  
 Support 24 hours a day: (please specify) \_\_\_\_\_

## Exercise:

In the past 3 months have you exercised at least 2 to 3 times per week?  Yes  No

How many minutes/hours do you exercise per day on average?  <1-2  >3-4

If yes, what type of exercise mode (check all that apply)?

- Walking  Pool  Bike  
 Fitness Center  Other: \_\_\_\_\_

Do you have exercise or therapy equipment at home (treadmill, bike, electrical stimulation units, weights, saebotex)?  Yes  No

If yes, what type? \_\_\_\_\_

- Equipment:
- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Glasses             | <input type="checkbox"/> Hearing Aids                   | <input type="checkbox"/> Oxygen            |
| <input type="checkbox"/> Walker              | <input type="checkbox"/> Rolling Walker                 | <input type="checkbox"/> Quad Base Cane    |
| <input type="checkbox"/> Single Point Cane   | <input type="checkbox"/> Crutches                       | <input type="checkbox"/> Manual Wheelchair |
| <input type="checkbox"/> Electric Wheelchair | <input type="checkbox"/> Brace/Orthotic                 | <input type="checkbox"/> Tub Bench         |
| <input type="checkbox"/> Bedside Commode     | <input type="checkbox"/> Eating/Bathing/Dressing Device |  |
| <input type="checkbox"/> Wheelchair Cushion  | <input type="checkbox"/> Adaptive Communication Device  |  |

***Things to keep in mind before applying to the START Program***

- *All treatment and therapy provided in the START Program are billable services except those associated with a research study. We bill third-party payers and also accept self-pay patients. Our financial counselors are happy to discuss payment plans and possible discount programs with patients whose insurance benefits have been exhausted.*
- *For those patients who qualify for research studies, all therapies provided as part of the study are free of charge.*
- *If you are a patient in a nursing home, insurance companies and Medicare/Medicaid traditionally will not pay for outpatient stroke therapy while you are living in a facility that offers these services. If your finances allow, you can pay for our services out of pocket but must have transportation to and from the facility. This service is not provided by Drake for outpatient services.*
- *Drake welcomes patients from other regions and understands the challenge of participating in a program that would require being away from home for an extended period of time. Currently, we do not provide long-term accommodations but would be happy to discuss options for the patient and family members.*
- *The START program is a unique approach for post-stroke patients but the success of recovery of basic tasks is as much dependent on the hard work and commitment of the patient as the skill and expertise of our clinicians and physicians.*
- *It is not a requirement of the START program for the patient to have previously been a patient – inpatient or outpatient – of Drake Center. It does require that they have received some traditional therapy immediately post stroke.*

## REVIEW OF SYSTEMS

Please indicate any symptoms or problems you have in each of these areas by checking yes or no:

System	Signs or Symptoms	No	Yes (explain the problem)
Constitutional	Fever, night sweats, weight changes, chills, fatigue		
Skin	Rash, itching, etc.		
Eyes	Vision loss, double vision, blurred vision		
Heart	Chest pain, rapid heart rate		
Lungs	Shortness of breath, wheezing		
Gastrointestinal	Pain, vomiting, diarrhea, constipation, blood in stool		
Genital, Urinary, Kidney	Sexual dysfunction, stones, blood in urine, Incontinence, frequency, Urgency, how many times do you get up during the night to urinate?		
Endocrine	Diabetes, thyroid disease		
Hematologic/ Lymph	Anemia, bleeding, clotting problems, enlarged nodes		
Musculoskeletal	Pain, weakness, loss of muscle		
Psychiatric	Depression, anxiety		
Neurologic	Seizure, syncope, memory loss, headache		
All of negative			

Do you have pain?  Yes  No Location: \_\_\_\_\_

Pain Intensity: None 1 2 3 4 5 6 7 8 9 10 Severe

Pain Quality:  Dull  Sharp  Aching  Stinging  Burning  Throbbing

Tingling  Locking  Popping  Grinding  Giving Away

Other: \_\_\_\_\_

Effects of pain on daily life, recreation, etc.: \_\_\_\_\_

Upon completion of our examination, we will send a report to your doctor. Where do you want us to send your report?

Primary Care Physician:  Yes  No

Referring Physician:  Yes  No

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_

Phone number: \_\_\_\_\_

**Patient Data Information:**

Alternative Contact Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Home Ph: \_\_\_\_\_

Home Ph: \_\_\_\_\_

Work Ph: \_\_\_\_\_

Work Ph: \_\_\_\_\_

Cell Ph: \_\_\_\_\_

Cell Ph: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Name of Secondary Insurance: \_\_\_\_\_

ID Number: \_\_\_\_\_

ID Number: \_\_\_\_\_

Group No: \_\_\_\_\_

Group No: \_\_\_\_\_

Insurance Ph. No: \_\_\_\_\_

Insurance Ph. No: \_\_\_\_\_

Claim Address: \_\_\_\_\_

Claim Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*\*\*Please attach a copy of both the front and back of your insurance card(s)**

**REHABILITATION SCREEN**

System	Sign or Symptom	No	Yes (explain the problem)
1. Communication	Difficulty speaking, finding words or being understood, mumbling, slurring		
2. Swallowing	Difficulty eating, drinking, or chewing, choking, coughing or gagging, drooling, feeling as if food is caught in mouth or throat		
3. Voice	Change in loudness or tone of voice, hoarseness		
4. Ears	Difficulty hearing		
5. Thinking Skills (Cognition)	Difficulty with memory, attention, planning, problem solving, and organizing your thoughts.		
6. Activities of Daily Living	Difficulty with bathing, grooming, feeding, toileting, uses adaptive equipment to complete tasks		
7. Home Management	Difficulty with cooking, cleaning, bills, living independently		
8. Hand Splint	Do you currently wear a hand splint on your affected arm?		
9. Exercise/ Workout	Difficulty doing an exercise program for your arm and/or leg?		
10. Transfers	Difficulty with standing up, getting into bed, getting on/off the toilet, getting in/out of the car		
11. Balance	Have you fallen in the past year?		
12. Walking	Difficulty walking by yourself?		Does someone provide assistance? Do you use a cane/walker? How far can you go?
13. Orthotic/Brace	Do you currently wear a leg brace on your affected leg?		
14. Wheelchair	Do you currently rely on a wheelchair for mobility in the house and community?		How old is your wheelchair?
15. Recreation/ Quality of Life	Do have concerns about how your stroke has affected you socially with leisure activities? Hobbies?		

What are your expectation/goals for your recovery? \_\_\_\_\_

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