

PREHAB INTAKE SUMMARY

Name: _____ Date of Birth: _____ Today's Date: _____

What joint are you having replaced? Hip Knee Left Side Right Side

Have you had a previous total joint replacement? No Yes → Which joint and when? _____

What is your goal after you receive a total joint replacement? _____

HOME ENVIRONMENT

Do you live: Alone With others

How many stairs do you have to get into your home from outside? _____ Is there a railing? Yes No

Do you have to climb stairs to get to: Bedroom? No Yes → How many? _____ Railing? Yes No

Bathroom? No Yes → How many? _____ Railing? Yes No

Laundry? No Yes → How many? _____ Railing? Yes No

In your bathroom, do you have: Tub Walk-In Shower

Is your bathroom equipped with any special equipment? None Grab bars in tub/shower

Grab bars by toilet Bath/Shower seat or bench

Raised toilet seat Other: _____

Do you have any of the following in your home? Throw rugs Pets Small Children

CURRENT FUNCTIONAL LEVEL

Have you had any falls in the last year? No Yes → Please explain: _____

Are you currently either working, volunteering, or providing caregiving duties? Yes No

If yes, please provide details: _____

Are you able to do the following?

Dressing activities: By myself With Assistance Stair climbing: By myself With Assistance

Bathing: By myself With Assistance Household chores: By myself With Assistance

Toilet hygiene: By myself With Assistance Driving: By myself With Assistance

Cooking: By myself With Assistance Grocery shopping: By myself With Assistance

Who will be assisting you with daily activities (dressing, bathing, mobility, & driving) after surgery & for how long?

MOBILITY/WALKING

Approximately how long or how far can you walk before needing to rest? _____

Do you use an assistive device to walk, such as a cane or walker? No Yes at home Yes in the community

What device(s) do you use? _____

Do you use assistive devices for any other activities, such as a reacher, sock aid, etc.? No Yes

If yes, please describe? _____

Are you currently receiving any community support services, such as Meals on Wheels, etc.? No Yes

If yes, please describe? _____

Name three (3) barriers you perceive may limit your ability to return home after surgery.

1. _____ 2. _____

3. _____

→→→→→ OVER →→→→→

09.0204



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Place
Patient Label
Here

MIAMI COUNTY MEDICAL CENTER
2100 Baptiste Dr., Paola, KS 66071

Revised/Effective
Date: 7/16
Initials: TM

MCMC No. 2216

OUTPATIENT REHABILITATION INTAKE SUMMARY

Languages you speak: English American Sign Language Spanish Other _____
 Preferred language for discussing healthcare: English American Sign Language Spanish Other _____
 Preferred Mode of communication: Verbal Sign Language Written Other _____

Past Medical History: Do you have any previous history of the following conditions?

High Blood Pressure:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Severe Emotional Disturbance:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Condition/Pacemaker:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Persistent Night Pain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Strokes:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Disorders/Short of breath:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Broken Bones (Fractures):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Excessive Fatigue:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Metal Implants:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frequent/Severe Headaches:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Unexplained Weight Loss/Gain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fibromyalgia:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Change in Bowel/Bladder Function:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizures:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any communicable disease:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ALLERGIES	REACTION
Do you have any allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list:	

OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS	Staff Use Only		
Do you have any other diagnoses or significant conditions? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list:	Time	Date	Signature

PREVIOUS PROCEDURES / SURGERIES	Staff Use Only		
Did you have any other previous procedures / surgeries? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list:	Time	Date	Signature

CURRENT MEDICATIONS, INCLUDING HERBALS	Staff Use Only		
Are you currently taking any medications, including herbals? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list: <div style="text-align: right; margin-right: 50px;"><input type="checkbox"/> See attached list</div>	Time	Date	Signature

Time
Date
Patient Signature