

THE REHABILITATION CENTER, THERAPEUTIC SOLUTIONS FOR CHILDREN AND ADULTS
1216 Hillcrest . 2009 Texoma Pkwy . Sherman . Texas . 75092 . (903) 893 -7457

CLIENT/FAMILY INFORMATION:

Patient's Name _____ Social Security # _____ Date _____
 Patient's Address _____ City _____ State _____ Zip _____
 Patient's Phone (H) _____ (Other) _____ ; _____
 Patient's Guardian/Other (if applies) _____ Relationship to Patient _____ Phone _____
 If child, lives with _____ Language Spoken at home _____ Age _____ Race _____ Weight _____ Height _____
 List Immediate Family Members Below:

Name	Relationship	Age	Name	Relationship	Age
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

MEDICAL HISTORY/INFORMATION:

Primary Physician's Name _____ Phone# _____ Who referred you to the Center? _____
 Besides hospitalization/surgeries, *in the past*, have you/child received an evaluation, testing, therapy or treatment for this problem?
 NO; If YES, explain _____
 Are you/child *currently* receiving services for this condition from other providers including HOME HEALTH?
 NO; If YES, list _____
 Do you/child have or ever had:
 High Blood Pressure Heart Disease Stroke Head Injury Major Surgery
 Glaucoma Cancer Dizziness Fainting Spells Pace Maker
 Shortness of Breath Poor Circulation Seizures Hearing Problems Vision Problems
 Behavior Issues Dizziness Diabetes Mental Disorder
 Learning Disability Other or details _____
 Is there a possibility patient could be pregnant? _____
 Is your/child's activity level restricted for medical reasons? NO YES – explain _____
 Do you/child use assistive devices?
 Glasses/contact Hearing Aid Dentures Walker Cain
 Wheelchair Communications Aid Other or details _____

Prescribed Medications (use back of sheet if needed)	Prescribing Physician's Name	Physician's Phone #
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Are you/child allergic to (food/drugs/other)? List: _____

EDUCATION HISTORY:

What is your highest educational level? _____ Occupation? _____
 What do you/child hope to accomplish through therapy at The Rehabilitation Center? _____
 What are your/child's hobbies or special interests? _____
 If Child, child's school/day care _____ Grade _____ Is child receiving "special education" services NO YES
 Describe any problems at school/day care _____

PREGNANCY/BIRTH HISTORY:

List pregnancy complications _____ Full Term NO YES, Hours of Labor _____
 Type of Delivery _____ Birthweight & Height _____ Describe anything unusual about the birth or child's condition after birth _____

TELL US:

I selected The Rehab Center for therapy because: Most Convenient Outstanding Services Monetary Reasons Dr/Other Referral
 I heard about the Center from (Check all that apply): Newspaper School Phone book Daycare provider
 Family/Friend Doctor Other: _____