Sparrow

Last Name, First Name	Physician
Date of Birth	

CARDIAC REHABILITATION INITIAL EVALUATION FORM

Please answer the following questions as completely as possible. **Please** use black ink only and **do not fill in shaded areas.** Shaded areas are for **OFFICE USE ONLY**. If you need help filling out this form, we would be happy to assist you.

Date of surgery/onset of problem:

Current Medical History:

***PREVIOUS TREATMENT(S)** for this condition

Health Care Provider	Name / Date	Health Care Provider	Name / Date
☐ Family Doctor		☐ Specialist	
☐ Other		☐ Other	

***DIAGNOSTIC TEST(S): Have you had any associated with your current condition? (If yes, please state results.)**

Test	Date / Result	Test	Date / Result

Therapist Comments: ☐ **Prior tests reviewed.**

***MEDICAL HISTORY:**

Past surgeries in last two years? ☐No ☐Yes, please list and date:

(Please check each box that applies) ☐ **Reviewed with patient (Unremarkable)**

Have you had any of the following: ☐ None

☐Heart disease/attack	☐Lung disease/asthma	☐Stroke	☐Arthritis (type: _____)
☐Pacemaker/defibrillator	☐Kidney disease	☐Head injury	☐Osteoporosis/osteopenia
☐High blood pressure	☐Liver disorder/hepatitis: _____	☐Headaches	☐Metal implants
☐Circulation problems	☐Thyroid disease	☐Seizures	☐Stomach disorders
☐Diabetes (type: _____)	☐Skin disease	☐Dizziness	☐Frequent nausea/vomiting
☐Blood issues/history of clot	☐Cancer (type: _____)	☐Swallowing problems	☐Bowel/bladder issues
☐HIV (+)	☐MRSA/VRE(+)	☐Mental health issues	☐Neuromuscular disease

☐ **Other medical history that we need to be aware of, i.e., accidents or other?** ☐ **None** _____

Hearing loss: ☐No ☐Yes **Hearing aids**: ☐No ☐Yes **Glasses/Contact lens**: ☐No ☐Yes

Allergies to: ☐ Tape/Latex ☐Adhesive ☐Environmental ☐ Drug Type_____

Do you smoke? ☐No ☐Yes, how many packs/day:_____ **Do you drink alcohol?** ☐No ☐Yes, how much: _____

List all current medications including over-the-counter types *(If you have a list, we will photocopy it.)

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***EMPLOYMENT:**

Are you currently working? ☐Full-time ☐Part-time ☐Retired ☐Disabled ☐Student ☐Unemployed

Occupation / Job Title / Responsibilities: _____

List any restrictions: _____

What problems are you having at work due to your condition: _____

_____

List any hobbies: _____

Therapist Comments: (Return to work goals, disability, restrictions, lifestyle, hobbies, home life.)

PERSONAL INFORMATION/ACTIVITIES OF DAILY LIVING:

Home: ☐1-story with/without basement ☐2-story home with/without basement ☐Apartment with/without elevator ☐Mobile Home ☐Other:

Stairs: Maximum # of stairs in your home: _____

When going up the stairs, are handrails on the: ☐Left ☐Right ☐Both ☐None

Live (with): ☐Alone ☐Spouse ☐Friend(s) ☐Family

Equipment: Assistive equipment used at home (lift chair, bathroom rails, etc): ☐ None ☐Yes, equipment used: _____

Prior to the current problem, did you walk using a device? ☐No ☐Cane ☐Crutches ☐Standard Walker ☐Rolling Walker ☐Other:

Falls: Number of falls you have had in the last month/year? ☐ None ☐Yes (If yes, number of falls last month: _____/ last year: _____)

Needs: Do you have any additional needs? ☐No ☐Yes (If yes, please check all that apply)

☐Interpreter ☐Large Print ☐Nutrition Counsel ☐Counseling ☐Support Groups ☐Other:

Do you have an advanced directive? ☐No ☐Yes **if not, do you want information about an advanced directive?** ☐No ☐Yes

Please review the list below and rate those tasks that your condition affects using the scoring guide below.
Only rate those tasks that apply to you

SCORING GUIDE 0=Able to perform at the same level as before injury or problem 10=Unable to perform activity

TASKS	RATING (0-10)	THERAPIST COMMENTS
Sitting		
Standing		
Walking		
Running		
Stairs		
Positional changes in bed		
Getting in/out of bed, chairs, car, etc.		
Housekeeping		
Yard work		
Leisure tasks		
Lifting / Carrying		
Personal care (grooming, bathing, dressing, toileting, etc.)		
Other:		
Other:		

ADDITIONAL COMMENTS: History reviewed with patient: ☐Yes ☐No

***Therapist(s) signature/date:**