Initial Assessment

Name:	Do you have any allergies?	**NIAGARA THERAPY,L.L.C.**
ID#:		2631 W 8th St
What brings you to therapy? Goals?		Erie, PA 16505
		Phone: 814.464.0627
	Allergy to Latex? ☐ No ☐ Yes	Fax: 814.464.0629

CURRENT MEDICATIONS

Medication	Dos/Freq	Medication	Dos/Freq	Medication	Dos/Freq

PAST MEDICAL HISTORY

	Yes	No	Comments		Yes	No	Comments
Tuberculosis (TB)				Asthma			
Respiratory (COPD)				Cancer			Chemo/Radiation
Stomach/Intestinal/Ulcer				Dizziness			
High Blood Pressure				Arthritis			
Low Blood Pressure				Osteoporosis			
Circulation/Vascular/Clots				Pregnant			
Heart Disease				Heart Attack			
Joint Replacement				Stroke			
Diabetes				Brain Injury			
Epilepsy/Seizures				Pacemaker			
Skin Problems				Headaches			
Bladder Control Difficulty				Cataract/Glaucoma			
Bowel Control Difficulty				MS/Fibromyalgia			
Blurry/Double Vision				Swelling			
Shortness of Breath				Depression			
Psychiatric History				Parkinson's			
Hepatitis				Autism/Asperger's			
Current Home care/aides?				ADHD			
Previous OT/PT/SLP?				Sensory Process Dis.			
Previous Chiropractic care?				Drink Alcohol?			How much?
Chemical Dependency				Smoker?			How much?

What major surgeries have you had (please list with most recent first):

Are there any religious or cultural considerations that may interfere or need to be observed in therapy? | No | Yes

Is there any other medical information not covered by this form?

What is your Height? _____ What is your Weight? _____

Have you ever fallen?	PAIN? ☐ No ☐ Yes ____/10
If yes, how often? Most Recent?	Location:
	☐Dull☐Sharp☐Burning☐Numb☐Throb
Home Environment:☐House ☐Apartment	☐Constant ☐↑ during the day ☐↓during the day
☐Single story ☐Multi-story	Makes it better:
Steps to enter? How Many?	Makes it worse:
Currently Living with: ☐ Alone ☐ Spouse/Significant other ☐ Parents ☐ Assist Living ☐ Group Home☐ _____	Barriers to Therapy:

EQUIPMENT

MOBILITY	☐Manual W/C	**BR**	☐Tub Bench/Seat	**MISC**	☐
☐Rolling Walker	☐Scooter	☐3 in 1 or BSC	☐Rails	☐Glasses	☐
Cane	☐Power W/C	☐Riser	☐Tub	☐Hospital Bed	☐

Staff Signature:_____ Date:_____

Staff Signature:_____ Date:_____