Daniel Drake Center
for Post-Acute Care | UC Health

Please return form to: **Daniel Drake Center**
Attn: Outpatient Clinic
151 W. Galbraith Rd.
Cincinnati, OH 45216
Phone: (513) 418-2470
Fax to: (513) 418-5913

STROKE RECOVERY CENTER

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 ☐ Eval only in the hospital ☐ Less than 1 month
☐ 1-3 months ☐ 4-6 months ☐ 7-9 months
☐ >9 months

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

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

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

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

FAMILY HISTORY

Does anyone related to you have (please circle):

☐ Hypertension ☐ Diabetes ☐ High Cholesterol

☐Heart Disease ☐ Migraines ☐ Seizures

☐Muscular Dystrophy ☐ Strokes ☐ Parkinson's Disease

☐ Alzheimer's Disease ☐ Neuropathy ☐ Thinking Problems

☐ Multiple Sclerosis ☐ Cancer (name type):_____

☐ Motor Neuron Disease (Lou Gehrig's Disease) ☐ Bowel/Bladder Control

☐ 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, saeboflex)? ☐ Yes ☐ No

If yes, what type? _____

Equipment:

☐ Glasses	☐ Hearing Aids	☐ Oxygen
☐ Walker	☐ Rolling Walker	☐ Quad Base Cane
☐ Single Point Cane	☐ Crutches	☐ Manual Wheelchair
☐ Electric Wheelchair	☐ Brace/Orthotic	☐ Tub Bench
☐ Bedside Commode	☐ Eating/Bathing/Dressing Device	
☐ Wheelchair Cushion	☐ 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 Daniel Drake Center for outpatient services.*
- *Daniel Drake Center 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 Daniel 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

Name:_____

Address:_____

City:_____State:_____Zip:_____

Phone number:_____

Referring Physician: ☐ Yes ☐ No

Name:_____

Address:_____

City:_____State:____Zip:_____

Phone number:_____

Patient Data Information:

Address: _____

_____

_____

Home Ph: _____

Work Ph: _____

Cell Ph: _____

Alternative Contact Name: _____

Relationship to Patient: _____

Address: _____

_____

_____

Home Ph: _____

Work Ph: _____

Cell Ph: _____

Primary Insurance: _____

ID Number: _____

Group No: _____

Insurance Ph. No: _____

Claim Address:

_____

_____

_____

Name of Secondary Insurance: _____

ID Number: _____

Group No: _____

Insurance Ph. No: _____

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? _____

_____

_____

_____