DLT Department of Labor and Training
RHODE ISLAND

ARRIGAN REHABILITATION CENTER – PATIENT INFORMATION INTAKE FORM

In order to expedite the Intake Process, please complete this form and bring it with you on the day of your admission. If you have any questions, please feel free to contact us at (401) 243-1200.

NAME:_____ DOB_____ ○Male ○Female

EMAIL ADDRESS: _____

HOME PHONE #: _____ CELL PHONE #: _____

ADDRESS: _____
Street Address, City, State, Zip Code

EMERGENCY CONTACT: _____
Name, relationship to you, phone number with area code

FAMILY PHYSICIAN: _____
Name, address, phone number with area code

PHYSICIAN FOR INJURY: _____
Name, address, phone number with area code

LENGTH OF TIME WITH EMPLOYER PRIOR TO INJURY: _____

WEEKLY AMOUNT OF WORKERS' COMPENSATION (OPTIONAL): _____

OCCUPATION: _____ LAST DAY OF WORK: _____

INJURY DATE: _____

LIST BELOW THE NAMES, ADDRESSES AND PHONE NUMBERS THAT APPLY:

ALL DOCTORS you want to have your reports sent to:

_____
_____
_____

ADDITIONAL REQUESTS for CASE MANAGERS:

_____
_____
_____

ATTORNEY:

_____
_____
_____

_____
_____
_____

Have you been to the Arrigan Center before? ○ ***Yes*** ○ ***No*** ***If yes, when?*** _____

Have you received an information letter from the Arrigan Center describing our services? ○ ***Yes*** ○ ***No***

Patient Name: _____ DOB: _____ DC Case # _____

To ensure your medical safety and readiness to participate in a treatment program, please answer the following questions:

_____ Height _____ Weight

PAST MEDICAL HISTORY: Have you ever had the following (*check all that apply*)?

- ☐ Asthma
- ☐ Seizure/Epilepsy
- ☐ High Cholesterol
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Stroke
- ☐ Pneumonia
- ☐ Cancer (type):_____
- ☐ Hepatitis
- ☐ Thyroid Disease
- ☐ Cirrhosis of the Liver
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Rhythm Problem
- ☐ AIDS
- ☐ HIV
- ☐ Acid/Stomach Reflux
- ☐ Arthritis
- ☐ Gout
- ☐ Phlebitis/Varicose Veins
- ☐ Emphysema (COPD)
- ☐ Tuberculosis
- ☐ Fibromyalgia
- ☐ Substance Abuse
- ☐ Depression
- ☐ Anxiety
- ☐ Other Psychiatric Illness

List any PREVIOUS SURGERIES (with dates):

1. _____
2. _____
3. _____
4. _____
5. _____

List any CURRENT MEDICATIONS & DOSAGES that you are taking:

1. _____
2. _____
3. _____
4. _____
5. _____

Are you currently having or have you ever had in the recent past any of the following (*check all that apply*)?

- ☐ Shortness of Breath
- ☐ Fainting/Blackouts
- ☐ Wheezing
- ☐ Irregular Heartbeat
- ☐ Chest Pain/Angina
- ☐ Severe Headaches
- ☐ Depression/Anxiety
- ☐ Seizures

List any known allergies to medications that you have:

_____

Social History:

Do you smoke? ○ Yes ○ No Amount per day:_____ Use alcohol? ○ Yes ○ No

Amount per week:_____ Other drugs? ○ Yes ○ No If so, which ones?_____

Marital Status _____ Number of children _____

Family History:

Have any of your parents, grandparents, brothers or sisters ever had a history of heart disease? ○ Yes ○ No

Patient Signature & Date: _____

***TO BE FILLED OUT BY ARRIGAN CENTER STAFF MEMBER.**

The above information has been reviewed with the patient by: **BP _____ P _____**

_____

Intake Coordinator (Print or Type Name)

_____

Intake Coordinator Signature & Date