ROLLING HILLS REHABILITATION CENTER
COMPREHENSIVE ASSESSMENT HISTORY AND PHYSICAL

RESIDENT NAME: _____

DIAGNOSIS
Current _____
Past _____
_____

MEDICATIONS _____
_____
_____
_____
_____

ALLERGIES _____

IMMUNIZATIONS Pneumovax: Date_____ Flu Vac: Date_____ Other: Date_____

PPD Date given:_____ Given by:____ Date read:____ Results:____mm Read by:_____

CHEST XRAY Date:_____ Results:_____

PHYSICAL EXAM Age:___ Height:____ Weight:____ BP:____ P:____ R:___ T:___

Head/Neck _____
Eyes/Ears/Nose/Throat:_____
Oral Cavity(dentures)_____
_____
Chest _____
Heart _____
Lungs _____
Abdomen _____

Genital _____
Urinary _____
Pelvic _____
Rectal _____
Extremities _____
Skin _____
Neurological _____
Mental Condition _____

Comments _____
_____

DIET/TEXTURE _____

ACTIVITY LEVEL/ RESTRICTIONS _____

SOCIAL NEEDS: _____
_____

SERVICES REQUESTED Frequency/specific treatment to be done.
PT _____ OT _____ ST _____

TREATMENTS/FREQUENCY (Skin treatment, dressing change, labdraw, accu check)
_____
_____

ACTIVITIES OF DAILY LIVING

DRESSING: Independent____
Assist 1 ____
Assist 2 ____

FEEDING: Independent _____
Set up _____
Fed by staff _____

TRANSFER: Independent _____
Assist 1 _____
Assist 2 _____
Mechanical lift/ stand _____

AMBULATION: Independent ____
Stand by Assist ____
Assist 1 ____
Assist 2 ____

DEVICES: Walker _____
Cane _____
Gait Belt _____
W/C _____
Commode _____

BOWEL/BLADDER: Continent _____
Incontinent _____
Urostomy/Foley _____
Colostomy _____

COMMUNICATION: Talks_____
Understand/Speaks English_____
Other language spoken _____

BEHAVIORS: Oriented____ Withdrawn____
Forgetful____ Combative____
Confused____ Wanders ____

DISABILITIES: Amputation____ Speech _____
Paralysis ____ Sensation ____
Contractures ____

BEHAVIOR NEEDS: _____

_____

_____

_____

SPECIAL NEEDS: _____

_____

_____

_____

LENGTH OF STAY Admit date_____ Discharge Date_____
DISCHARGE PLACEMENT _____

I certify that this patient's medical conditions and related needs are essentially as indicated above, and that inpatient care is appropriate at this time. I also certify that this patient is free of communicable tuberculosis and clinically apparent communicable disease.

PHYSICIAN SIGNATURE: _____ **DATE** _____

To be signed after admission
I have reviewed this History and Physical and Plan of Care. I agree with the Plan of Care.
Primary N.H. **Physician Signature:** _____ **Date:** _____