burn/wound care – patient information

Date:_____ **Patient's name:**_____ **Date of birth:**_____

During the first visit, we will discuss your answers on this form. This helps us decide what tests/procedures we need to do. Your comments are very important. If possible, please complete this information at home and bring it with you to your first session.

Thank you in advance for your information.

Please bring your referral and insurance information to your first visit. Please bring all ointments ordered by the doctor for treatment of the burn/wound. Please take pain medicines, if ordered by your doctor, 30 minutes before your visit. Please wear clothes that will allow us to easily treat your injury. Please bring small items such as bottle/drink, small toy, blanket, etc., to comfort the patient, if the patient is young.
If you have any questions or concerns before your visit, please feel free to call us.

Cook Children's Medical Center	Cook Children's Northeast Rehab	Cook Children's SPORTS Rehab
682-885-7660	817-347-2955	817-347-2925

Your requests and thoughts:

What is the reason for this therapy visit? Please describe how and when the patient was burned/wounded: _____

_____

Describe any immediate medical care received: _____

What do you hope to accomplish with therapy? _____

Please list customs, religious beliefs or wishes that we need to know about: _____

_____

During treatment, we will give you directions for practicing activities at home. Do you have a favorite way of learning new information? ☐ Pictures ☐ Writing ☐ Demonstration ☐ No Preference

Please list any other concerns that you would like us to know: _____

_____

Medical history/information:

Is the patient allergic to any medicines or foods? Please list: _____

_____

Who is the patient's primary doctor and phone number? _____

What other doctors (specialists) treat the patient? _____

What medicines is the patient currently taking? _____

What specific medical condition(s) does the patient have? _____

_____

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Are there certain precautions that we should know about? _____

Please list the patient's hospitalizations and surgeries (with approximate dates): _____

_____

Has the patient had X-Rays, CT scans, or MRI for this condition? Results? _____

_____

Are the patient's immunizations current? ☐ Yes ☐ No

Does the patient use any special equipment/and or bracing? ☐ Yes ☐ No

Please list, if yes: _____

_____

Has the patient had previous therapy for the current condition or for other conditions?

_____

_____

When is the patient's next appointment with the referring doctor or primary care doctor? _____

_____

Along with your child's physical health, we would like to know about your child's mental health.

☐ Yes ☐ No Are there any family issues that might impact your child's care? If so, please share.

_____

☐ Yes ☐ No Have you seen any changes in your child's moods or behavior? If so, please share.

_____

Thank you for your information.

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