(Place Patient Identification Sticker Here)

OUTPATIENT MEDICAL SCREENING

PATIENT INFORMATION

Patient Name: ______________________________ Date of Birth: __________

Current Diagnosis: ______________________________ Date of Injury (if applicable): __________

Currently: (circle) Working Not Working Retired Other: ______________________________

Occupation (or previous occupation): ______________________________

What is phone number and/or email we can best reach you for appointment reminders? (_____) ______________

Email: ______________________________

Emergency contact person and phone number: ______________________ (_____) __________

Type of housing: (circle) House Apartment Condo Other: ______________________________

Do you have stairs? (circle) Yes No If yes, do you have rail? Yes No

Do you have issues with: (circle) Hearing Vision

If yes to any above, any special accommodations? ______________________________

Do you have any cultural or religious practices that would impact your treatment? ______________________________

____

HISTORY:

Social:

Regular Exercise: (circle) Yes No Type of exercise: ______________ How Often? __________

Tobacco Use: (circle) Never Quit – how long?__________ Still smoke – how much?______________

Do you drink alcohol? (circle) Yes No If yes, how often? (circle) Daily Weekly Occasionally Socially

Have you had any major life changes in past year? (circle) Yes No

If yes, explain:______________________________

____

Have you had a fall in the past year? (circle) Yes No Near fall? Yes No

If yes, explain:______________________________

____

Do you have a pacemaker or implant of any kind? (circle) Yes No If yes, explain: ______________________________

____

Medical:

Please circle if you have, or have had, any of the following:

anemia	circulation problems	high blood pressure	pelvic inflammatory disease
asthma	depression	kidney problems/infection	pneumonia
bladder problems/UTI	diabetes	liver problems	sexually transmitted disease/ HIV
blood clots	dizziness	lung problems	stroke
bone fracture	epilepsy/seizures	multiple sclerosis	thyroid problems
bone or joint infection	eye problems	osteoarthritis/rheumatoid arthritis	tuberculosis
cancer- type __________	heart problems	osteoporosis/osteopenia	other: __________
chest pain/angina	hepatitis		

Please list any allergies: ______________________________

Please list any current prescription medications or supplements you are taking (or provide a list we may copy): __________

____

____

____

PS002116.1215 REV

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Please list any surgeries or other conditions for which you have been hospitalized:

Date	Reason
___________	____
___________	____
___________	____
___________	____
___________	____

What is your primary reason for seeking therapy today?______________________________

Describe your symptoms and when they began: ______________________________

____

Is your problem due to a motor vehicle accident? (circle) Yes No

Did your problem occur at work? (circle) Yes No

Any previous treatments/ therapies for this condition? (circle) Yes No Any current therapy (home health, etc)? Yes No

If yes, when? ____________________ Where?______________________________

Have you had any imaging studies done for this problem? (x-ray, MRI, etc) Yes No

If yes, please explain: ______________________________

My symptoms are currently: (circle) Getting better About the Same Getting Worse

Please rate your pain (if any) using the following scale:

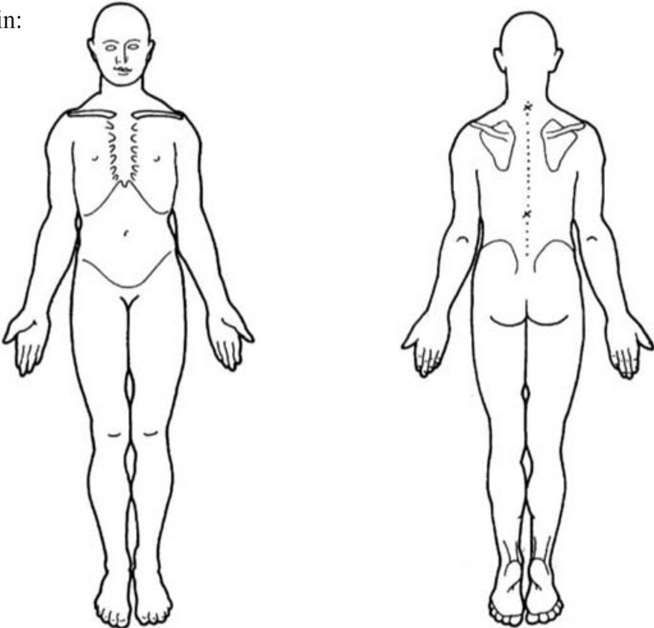
0	1	2	3	4	5	6	7	8	9	10
None		Annoying		Uncomfortable		Need Medication				Emergency Room

Currently: __________ Best: __________ Worst: __________

What increases your pain? ______________________________

What decreases your pain? ______________________________

Please mark on figure below the location(s) of your pain:



Therapist signature:____________________________Date ____________________ Time: ________________