Rehabilitation Screening/Confidential Medical History

Patient's Name: _____ **Age:**_____ **Date:**_____

Please complete the following questions to the best of your ability. This will help us to develop a treatment with you that meet your individual needs.

1. Reason for this visit? _____
2. Date of injury or when problem began: _____
   a. Date it worsened (if applicable): _____
3. How did your current problem begin? ____ lifting ____ twisting ____ falling ____ motor vehicle accident ____ unknown ____bending ____ other: _____
4. Were you hospitalized for this problem? ____ yes ____ no If yes, give dates:_____
5. Did you have any diagnostic tests (X-rays, MRI, CT Scan)?_____
   Results? _____
6. Please mark the areas where you have seen a decline in your abilities with your most recent condition:

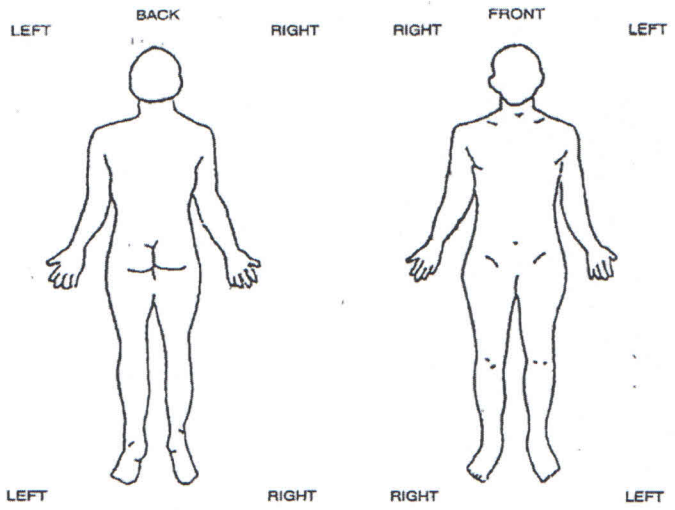
☐ Coughing/Sneezing	☐ Driving	☐ Lifting	☐ Balance
☐ Sleeping	☐ Rising from sitting	☐ Carrying Objects	☐ Steps/Stairs
☐ Lying down	☐ Standing	☐ Reaching/Lifting overhead	☐ Exercise routine
☐ Getting in/out of bed	☐ Walking	☐ Turning head/trunk	☐ Work duties
☐ Coughing/Sneezing	☐ Bending	☐ Dressing/Grooming	☐ Home duties

☐ Other: _____

7. Have you experienced similar symptoms before? __ yes __ no
   a. Indicate on the body diagrams where your symptoms occur:

Check any that you are experiencing:

- ❑ Aching
- ❑ Stabbing
- ❑ Pins & needles
- ❑ Numbness
- ❑ Burning



b. Rate your pain using the following scale, with one being the least amount of pain and 10 being very severe pain:

During rest:	1	2	3	4	5	6	7	8	9	10:
During activity	1	2	3	4	5	6	7	8	9	10

Patient's Name: _____

8. Are you presently working? ___ yes ____ no. Occupation:_____
   If working, is it ____ light/modified duty ___ regular duty?

9. What type of exercise do you regularly perform (prior to injury) and how often? _____

   _____

   What hobbies are you involved in?_____

10. Have you ever been diagnosed with any of the following?

___Cardiac Problems	___Diabetes	___ Asthma	___Infectious Disease
___Hypertension	___Osteoarthritis	___Orthopedic Problems	___Autoimmune Disease
___ Pacemaker	___Rheumatoid Arthritis	___GI problems	___Stroke/TIA
___Cancer	___Seizures	___Multiple Sclerosis	___Open wound
___ Fibromyalgia	___Depression	___Drug/Alcohol Dependency	

11. Have you ever had a broken bone or fracture? ____ yes ____ no If yes, which body part:_____ When:_____

12. Please list any major surgeries with dates:_____

_____

_____

13. Any previous physical therapy, chiropractic care or other treatment? _____ yes _____ no

14. Do you smoke? ____ yes ____ no If yes, number of packs/day? _____

15. Are you pregnant? ____ yes ____ no

16. List any medication allergies or latex allergy:_____

_____

17. List all prescription and over-the-counter medications you are currently taking **or provide us with a separate list**

_____

_____

_____

_____

18. What are your goals for physical therapy?

_____

_____

19. Is this a work-related injury? ____yes _____no
    If yes, will this be filed through your personal insurance or worker's compensation? _____