

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. Date of injury or when problem last caused you to seek medical attention: _____

2. How did your current problem begin? ___ lifting ___ twisting ___ falling ___ motor vehicle accident ___ unknown ___ other: _____

3. Were you hospitalized for this problem? ___ yes ___ no If yes, give dates: _____

4. Are you currently being seen by any of the following? ___chiropractor ___osteopath ___ physical therapist ___occupational therapist ___psychiatrist/psychologist If you are seeing any of the above, please describe the reason: _____

5. Medicare patients: Have you had physical, occupational or speech therapy any time in 2010? ___ yes ___ no If you answered yes, where? _____

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

7. Are you ___right or ___ left handed?

8. Do you use a: cane walker other: _____ none

9. What type of exercise are you currently doing? _____

- 10. Do you currently experience any of the following?
 Cardiac Problems Diabetes Hypertension
 Orthopedic Problems Rheumatoid Arthritis GI problems
 Cancer Seizures Multiple Sclerosis
 Fibromyalgia Depression Drug/Alcohol Dependency

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

12. Do you smoke? ___ yes ___ no If yes, number of packs/day? _____

13. Are you pregnant? ___ yes ___ no

14. How would you describe your overall health ___ excellent ___ very good ___ good ___ fair ___ poor

15. List any medication allergies _____

16. List all prescription or over-the-counter medications you are currently taking if you have not provided this information already: _____

17. Rate your pain using the following scale, with 0 being no pain and 10 being very severe pain:
During rest: 0 1 2 3 4 5 6 7 8 9 10
During activity: 0 1 2 3 4 5 6 7 8 9 10

18. Current living situation: ___ live alone ___ live with spouse/family ___ live in assistant living ___ other:

19. What are your goals of therapy? _____