TRI-STATE PHYSICAL THERAPY

Rehabilitation Screening/Confidential Medical History

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

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

1. Date of injury/illness 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 date(s): _____

4. Are you currently being seen by any of the following? __dentist **__chiropractor** __osteopathic doctor
__ physical therapist __occupational therapist __psychiatrist/psychologist

If you are seeing any of the above, please describe the reason: _____

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

6. Are you ____right or ____ left handed?

7. Do you use a: □ cane □ walker □ none □ other: _____

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

9. Do you currently experience any of the following?

□ Cardiac Problems/Pace Maker	□ Diabetes	□ Hypertension
□ Rheumatoid Arthritis	□ GI problems	□ Cancer
□ Seizures	□ Multiple Sclerosis	□ Fibromyalgia
□ Depression/Anxiety	□ Drug/Alcohol Dependency	□ Other: _____

Describe details: _____
_____

10. Please list all surgeries and the dates: _____
_____

11. Have you ever had a broken bone or fracture? ___ yes ___ no. If **yes**, when? _____
Which body part? _____

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

13. Are you pregnant? ___ yes ___ no

14. List any medication allergies_____

15. List all prescription and over-the-counter medications you are currently taking or provide a separate list:
_____

16. What are your goals of therapy? _____

17. How would you rate your present health: _____ excellent _____ very good _____ fair _____ poor.

18. Do you require any assistance for self-care or activities of daily living:_____ yes _____no
If yes please specify who assists in care?_____

19. Emergency contact name: _____ Phone:_____