Physical Medicine and Rehabilitation Department

Medical Screening Form

Please complete the following form to the best of your ability to assist your therapist in performing a thorough and efficient evaluation. If you do not know the answer to a question, please leave it blank.

NAME:_________________________________ AGE: ______

OCCUPATION: ____

In order to respect and safeguard your privacy, please answer the following:

May we leave a message with anyone answering the phone: Yes ___ No _____

If no, please specify below the names of individuals with whom we may leave a message:
Name: _____________ Relationship ____________
Name: _____________ Relationship ____________

EMERGENCY CONTACT: name:_________________phone number:_____________________

PRIMARY PHYSICIAN (include phone #): ________________________

In the last year have you seen or been under the care of any of the following?

___ Medical Doctor (MD) ___ Orthopedist ___ Psychiatrist/Psychologist
___ Neurologist ___ Cardiologist ___ Chiropractor
___ Eye doctor ___ Urologist/Gynecologist ___ Ear, Nose & Throat doctor (ENT)
Other: ____

List current prescriptions/over the counter medications (include vitamins and herbals):

____

____

List current diagnosed medical conditions:

____

____

List conditions/surgeries for which you have been hospitalized, with approximate date:

____

List known allergies: ____

During the past month have you been feeling down, depressed, or hopeless? YES NO
Have you ever smoked cigarettes? _____ If yes, how much/often? ______________________
Do you drink alcohol? _____ If yes, how much/often? ________________________________

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Have **you** ever been diagnosed with or experienced any of the following?

YES	NO	Osteoporosis	YES	NO	Glaucoma/Macular degeneration
YES	NO	High Blood Pressure	YES	NO	Epilepsy/seizures
YES	NO	Stroke/TIA	YES	NO	Cancer
YES	NO	Heart Disease/Cardiac Problems	YES	NO	Diabetes
YES	NO	Mental Illness	YES	NO	Arthritis
YES	NO	Head Trauma/Loss of consciousness	YES	NO	Ear Infections
YES	NO	Chemical Dependency	YES	NO	Neurological Disorder
YES	NO	Peripheral Neuropathy	YES	NO	Cataracts
YES	NO	Asthma	YES	NO	Peripheral Vascular Disease
YES	NO	Vestibular dysfunction	YES	NO	Emphysema
YES	NO	Osteoarthritis	YES	NO	Rheumatoid Arthritis
YES	NO	Lymphedema	YES	NO	Urinary Incontinence
YES	NO	Neck/Cervical Problems	YES	NO	Antibiotics
YES	NO	Hearing Impairment	YES	NO	Tinnitus/Ringing in ear
YES	NO	Headaches/Migraines	YES	NO	Orthostatic Hypertension
YES	NO	Depression/Anxiety/Panic Attacks	YES	NO	Hepatitis
YES	NO	Renal/Kidney Disease	YES	NO	Tuberculosis
YES	NO	Broken bones	YES	NO	Pacemaker
YES	NO	Deep Vein Thrombosis	YES	NO	Pulmonary Embolism

Have you recently experienced:

YES	NO	weight loss/gain	YES	NO	nausea
YES	NO	dizziness/lightheadedness	YES	NO	sudden weakness
YES	NO	fatigue	YES	NO	shortness of breath
YES	NO	fever/chills/sweats	YES	NO	pain that wakes you up at night
YES	NO	leg cramping	YES	NO	numbness/tingling

Number of times you have fallen this past year: _____ Date of last fall:__________________

Rate your fear of falling (please indicate a number):

POOR 1 2 3 4 5 6 7 8 9 10 HIGH

Do you use an assistive device? YES NO If yes, please list type:_____________________

Do you live alone? YES NO

How many times per week do you engage in social activities with family/friends? __________

In general, your lifestyle is:

ACTIVE 1 2 3 4 5 6 7 8 9 10 INACTIVE

Please choose your preferred method of learning:

___ Demonstration ("watching") ___ Practice ("doing")

___ Written/Pictures ("reading") ___ Discussion ("hearing")

Have you ever been hurt by a family member or significant other?________________________

Do you feel unsafe in your current relationship?_______________________________________

Have you been left alone too long so that your basic needs are not being met?_______________

Has anyone taken anything that belongs to you without your OK?_________________________

____

Patient Signature Date

------------------------PLEASE DO NOT WRITE BELOW THIS LINE------------------------

Based on the assessment and the questions above, is there an indication of abuse, neglect or exploitation?_________________

____

Therapist Signature Date Time