**Medical History/Rehab Screening**

Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete the following questions to the best of your ability.

1. What is the reason for your physical therapy visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Date of injury/illness or when problem last caused you to seek medical attention \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. How did your current problem begin? 🞏 Lifting 🞏 Twisting 🞏 Falling 🞏 Motor vehicle accident

🞏 Unknown 🞏 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Were you hospitalized for this problem? 🞏 Yes 🞏 No if yes, give dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Are you currently being seen by any of the following? 🞏 Dentist 🞏 Chiropractor 🞏 Osteopath 🞏 Massage Therapy

🞏 Physical Therapy 🞏 Occupational Therapy 🞏 Psychiatrist/Psychologist 🞏 Naturopathic Doctor

If you are seeing any of the above, please describe the reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Have you had physical/speech/occupational therapy since January of this year? 🞏 Yes 🞏 No

7. Are you presently working? 🞏 Yes 🞏 No Occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If working, is it 🞏 Light/Modified duty 🞏 Regular Duty 🞏 Full-time 🞏 Part-time

8. Are you 🞏 Right Handed 🞏 Left Handed Do you use a 🞏 Cane 🞏 Walker 🞏 None 🞏 Other\_\_\_\_\_\_\_\_\_\_\_\_\_

9. What type of exercise are you currently doing? ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Do you have a history of or currently experience any of the following? 🞏 Heart/Cardiac Problems 🞏 Diabetes

🞏 High/Low Blood Pressure 🞏Orthopedic/Joint Problems 🞏 Rheumatoid arthritis 🞏 Gout 🞏 Osteoporosis

🞏 GI Problems (bloating, gas, constipation, diarrhea, IBS) 🞏 Cancer 🞏 Seizures 🞏 Multiple Sclerosis

🞏 Fibromyalgia 🞏 Depression 🞏 Anxiety 🞏 Drug/Alcohol Dependency 🞏 Stroke 🞏 Change in appetite

🞏 Pacemaker 🞏 Hyper/Hypothyroid 🞏 Bowel/Bladder problems 🞏 Difficulty Sleeping 🞏 Hernia

🞏 Food Allergies/intolerances 🞏 Asthma 🞏 Shortness of breath 🞏 Dizziness 🞏 Weight/energy loss

11. Have you ever had surgery or a broken bone or fracture? 🞏 Yes 🞏 No

If yes, which body part 1. \_\_\_\_\_\_\_\_\_\_ When \_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_ When \_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_When \_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_ When \_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_ When \_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_ When \_\_\_\_\_

12. Do you smoke? 🞏 No 🞏 Yes, number of packs/day? \_\_\_\_\_\_\_\_\_\_ Are you pregnant? 🞏 Yes 🞏 No

13. Your stress level in the past 4 weeks – circle one No stress 0 1 2 3 4 5 6 7 8 10 High stress

14. Living situation: 🞏 Alone 🞏 With other 🞏 With assistance 🞏 1-story 🞏 2-story

15. List any medication or other allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16. List all prescription or over-the-counter medications you are taking for the problem you are being treated for

today \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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17. How would you describe your perception regarding the relationship between food you eat and the health of your

body? The relationship is: 🞏 Strong 🞏 Fair 🞏 No relationship

18. How willing are you to alter your food intake if necessary? 🞏 Very 🞏 Some what 🞏 Not likely

19. How would you describe your perception regarding the relationship between exercise and the health of your

body? The relationship is: 🞏 Strong 🞏 Fair 🞏 No relationship

20. How willing are you to alter your exercise routine if necessary? 🞏 Very 🞏 Some what 🞏 Not likely

21. How much time are you willing to dedicate per day toward your health/healing?

🞏 15 min 🞏 30 min 🞏 1 hour 🞏 Whatever it takes 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

21. What are your goals for therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_