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MEDICAL HISTORY SCREENING

PATIENT'S NAME: _____

DATE: _____

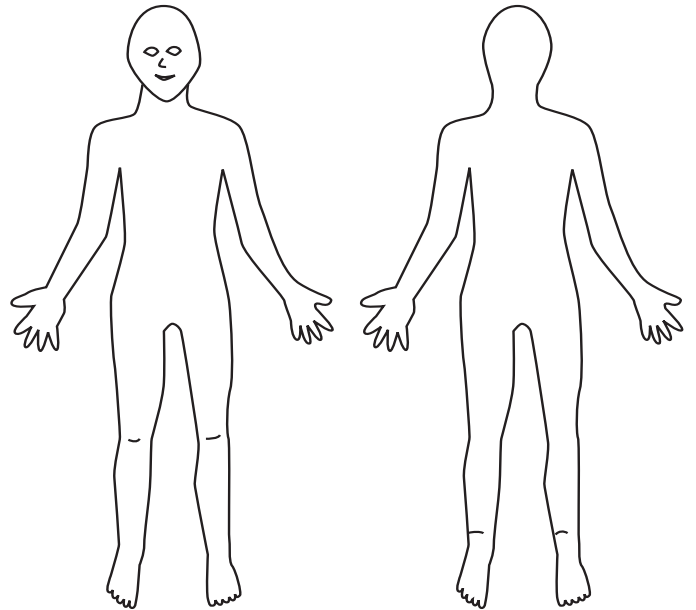
What is the reason for your visit today? List your chief complaint:

Please indicate the areas where you are experiencing pain/symptoms:

(Use the symbols in the table below to describe your pain/symptoms)

- //// PAIN
- XXXX BURNING
- PINS AND NEEDLES
- ==== NUMBNESS

OTHER COMPLAINTS: _____



If you are having pain, rate the severity on a scale of 0-10, where 0 is no pain and 10 is the most severe pain:

AT BEST: 0 1 2 3 4 5 6 7 8 9 10 (CIRCLE ONE NUMBER)

AT WORST: 0 1 2 3 4 5 6 7 8 9 10 (CIRCLE ONE NUMBER)

AT THIS TIME: 0 1 2 3 4 5 6 7 8 9 10 (CIRCLE ONE NUMBER)

Was your injury/illness related to an automobile accident? YES NO

Was your accident job-related? YES NO

Are you receiving therapy due to a long-term illness? YES NO

If so, how long have you been out of work? _____

Are you receiving any public assistance or disability benefits? YES NO

Are you or your family having difficulty adjusting to your illness? YES NO

Are you experiencing personal problems (relationship, parenting, etc.)? YES NO

Have you had kidney surgery? YES NO

If yes, date: _____

Have you received maintenance dialysis treatment? YES NO

What are your goals for therapy?

MEDICAL HISTORY SCREENING

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DO YOU HAVE A HISTORY OF (CHECK ALL THAT APPLY AND LIST DETAILS BELOW):

- | | | | |
|--|---|---|---|
| <input type="radio"/> JOINT REPLACEMENT/IMPLANTS | <input type="radio"/> ALLERGIES / ASTHMA | <input type="radio"/> HEADACHES | <input type="radio"/> BREATHING PROBLEMS |
| <input type="radio"/> KIDNEY DISEASE | <input type="radio"/> ULCERS / SEIZURES | <input type="radio"/> RECENT CHANGE IN HEALTH | <input type="radio"/> CANCER |
| <input type="radio"/> DIABETES | <input type="radio"/> HIGH BLOOD PRESSURE | <input type="radio"/> HEART DISEASE | <input type="radio"/> ANGINA/CHEST PAIN |
| <input type="radio"/> OSTEOPOROSIS | <input type="radio"/> ARTHRITIS | <input type="radio"/> STROKE | <input type="radio"/> NAUSEA / VOMITING |
| <input type="radio"/> FEVER / CHILLS | <input type="radio"/> UNEXPLAINED WEIGHT LOSS | <input type="radio"/> DIZZINESS OR FALLS | <input type="radio"/> CHANGES IN BOWEL/BLADDER FUNCTION |

DETAILS:

LIST CURRENT MEDICATIONS:

ARE YOUR SYMPTOMS:

- GETTING WORSE SAME IMPROVING

HOW WELL DO YOU SLEEP AT NIGHT?

- FINE MODERATE DIFFICULTY ONLY WITH MEDICATION

ARE YOU CURRENTLY:

- PREGNANT YES NO
DEPRESSED YES NO
UNDER STRESS YES NO

ACTIVITIES/SPORTS/HOBBIES:

DATE OF LAST PHYSICAL EXAMINATION:

PATIENT'S SIGNATURE:

DATE:

MEDICAL HISTORY SCREENING

SOCIAL SERVICE SCREENING FORM

TO PROVIDE HIGH-QUALITY SERVICE TO OUR PATIENTS DURING THEIR REHABILITATION, A SOCIAL WORKER IS AVAILABLE FOR CONSULTATION. PLEASE ANSWER THE FOLLOWING QUESTIONS BELOW TO HELP US BETTER MEET YOUR NEEDS.

1. DO YOU NEED ASSISTANCE WITH ANY OF THE FOLLOWING?

- | | | |
|--------------------|---------------------------|--------------------------|
| TRANSPORTATION | <input type="radio"/> YES | <input type="radio"/> NO |
| SHOPPING / ERRANDS | <input type="radio"/> YES | <input type="radio"/> NO |
| DOMESTIC CHORES | <input type="radio"/> YES | <input type="radio"/> NO |
| MEALS | <input type="radio"/> YES | <input type="radio"/> NO |
| PERSONAL CARE | <input type="radio"/> YES | <input type="radio"/> NO |

OTHER: _____

2. DO YOU HAVE SOMEONE TO ASSIST YOU WITH HOUSEHOLD OR DAILY TASKS? YES NO

3. HAS YOUR INJURY, ILLNESS OR DISABILITY CAUSED ANY OF THE FOLLOWING:

- | | | |
|---------------------------|---------------------------|--------------------------|
| FINANCIAL PROBLEMS/STRESS | <input type="radio"/> YES | <input type="radio"/> NO |
| FAMILY PROBLEMS | <input type="radio"/> YES | <input type="radio"/> NO |
| ANGER | <input type="radio"/> YES | <input type="radio"/> NO |
| SADNESS | <input type="radio"/> YES | <input type="radio"/> NO |
| ANXIETY | <input type="radio"/> YES | <input type="radio"/> NO |
| FRUSTRATION | <input type="radio"/> YES | <input type="radio"/> NO |

OTHER: _____

4. ARE YOU HAVING DIFFICULTY COPING WITH PAIN? YES NO

5. HAVE YOU EVER HAD PHYSICAL THERAPY BEFORE? YES NO

6. ARE YOU A MEDICARE PATIENT? YES NO