



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 meets 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?
 Dentist 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 2009?**
 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. List any medication allergies: _____
15. List all prescription or over-the-counter medications you are currently taking **if you have not currently provided this information already:**

16. What are your goals of therapy?

Eval / Progress / Discharge Date: _____

FUNCTIONAL ASSESSMENT QUESTIONNAIRE

Patient's Name: _____ DX: _____ Number of Visits: _____

Using the key below please circle one answer in each box that indicates your ability to do the following activities.

Key: 0 = Unable 1 = Very Difficult 2 = Moderately Difficult 3 = Minimally Difficult 4 = Normal

ACTIVITY	SCORE				
1. Sleep normally	0	1	2	3	4
2. Up and down stairs	0	1	2	3	4
3. Food prep / cooking / eating	0	1	2	3	4
4. Walking	0	1	2	3	4
5. Grooming (bath, comb hair, shave, etc.)	0	1	2	3	4
6. Getting up / down from chair or bed	0	1	2	3	4
7. Dressing – manage normal dressing activities	0	1	2	3	4
7a. Dressing – tie shoes / button shirt	0	1	2	3	4
8. Lifting / carrying up to 10 pounds	0	1	2	3	4
9. Sitting for normal periods of time	0	1	2	3	4
10. Standing for normal periods of time	0	1	2	3	4
11. Reaching above head or across body	0	1	2	3	4
12. Leisure / recreational / sports activities	0	1	2	3	4
13. Squatting down to pick up item	0	1	2	3	4
14. Running / jogging	0	1	2	3	4
15. Driving	0	1	2	3	4
16. Job requirements – can do all activities required of my job	0	1	2	3	4

PAIN SCALE: Please circle the number that describes the pain you have experienced over the last week with 0 being no pain and 10 the worst imaginable had.

0 1 2 3 4 5 6 7 8 9 10