Northwest THERAPY

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. M**edicare 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