OUTPATIENT SCREENING FORM
Rehabilitation Services Department: Physical Therapy/Occupational/Speech Therapy

Physical Therapy Notes

Please fill out this form prior to your initial treatment session. Check the box if you have had any of the following:

___diabetes	___dizziness	___osteoporosis	___arthritis
___tunnel vision	___heart murmur	___vertigo	___high blood pressure
___stroke	___congestive heart failure	___lightheadedness	___fracture (broken bones)
___heart disease	___migraine headaches	___epilepsy/seizures	___kidney disease/dialysis
___liver disease	___circulatory problems	___lung disease (emphysema)	
___varicose veins	___cancer	___neurological problems (MS, GB, ALS, etc.)	
___rheumatic fever	___asthma	___ cataract/macular degeneration	

___metal implants – location: _____

Please answer all the following:

I have fallen 2 or more times in last 12 months	No	Yes
Pacemaker	No	Yes
Latex Allergy	No	Yes
Skin Allergy	No	Yes
Are you currently receiving home health services	No	Yes
Women: Is there a chance you are pregnant	No	Yes
Medication Allergy	No	Yes

** If yes, list your medication allergies: _____

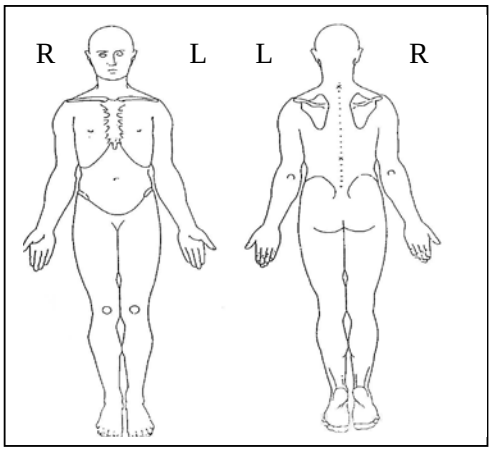
I understand the following: **No** **Yes** _____ **initial**

Your success is our sincere goal! Please be informed that missed/cancelled appointments can negatively impact your therapy outcomes and also takes away treatment times which could have been utilized for our other patients. Any combination of 3 or more missed/cancelled appointments without adequate notice prompts our right to cancel remaining appointments and discharge your therapy with notification to your physician.

Please answer all questions below, ONLY for the diagnosed condition being treated per your referral/ order to our department:

When did your condition first start (please provide date)? _____
When do you return to your doctor who referred you here? _____
List relevant hospitalizations/surgeries for the current problem (please provide dates) _____

Please indicate on body chart location of pain.



Please rate current level of pain on 0 – 10 scale:
0/10= no pain 10/10=worst pain (circle one)

0 1 2 3 4 5 6 7 8 9 10

_____
Patient's signature Date

_____
Therapist's signature Date/Time

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PLACE PATIENT LABEL HERE