YAVAPAI REGIONAL MEDICAL CENTER
PHYSICAL REHABILITATION SERVICES

MEDICAL SCREENING

MAKE A CHECKMARK (✓) IN BOXES APPROPRIATE FOR YOUR RESPONSE

WHAT ARE YOU ARE SEEKING THERAPY FOR?

WHEN DID PROBLEM(S) BEGIN OR DATE OF SURGERY/INJURY?

(MONTH) (YEAR)

HOW ARE YOUR SYMPTOMS SINCE ONSET? (CHECK ONE)

☐ Getting Worse ☐ The Same ☐ Improving

HAVE YOU EVER HAD THE PROBLEM(S) BEFORE?

☐ NO ☐ YES

WHAT IS YOUR CURRENT PAIN LEVEL TODAY?

0 1 2 3 4 5 6 7 8 9 10

FOR THIS PROBLEM CIRCLE THE LEAST AND WORST PAIN LEVEL THAT YOU HAVE EXPERIENCED:

0 1 2 3 4 5 6 7 8 9 10

FOR THIS CURRENT PROBLEM IS YOUR PAIN (CIRCLE)

NEVER INTERMITTANT OCCASIONAL FREQUENT CONSTANT

HOW ARE YOU CURRENTLY TAKING CARE OF THE PROBLEM(S)?

ARE YOU RECEIVING ANY OTHER TREATMENT FOR THIS PROBLEM?

☐ No ☐ Yes

EXPLAIN_____

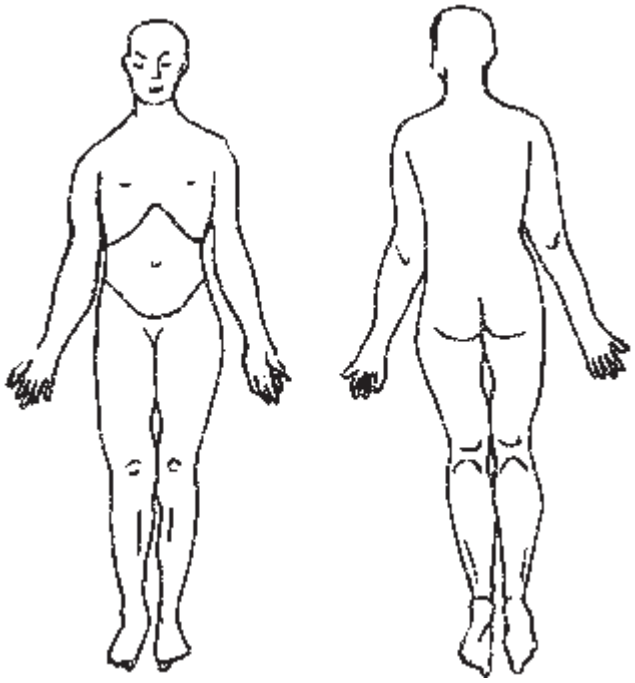
_____

HAVE YOU HAD ANY DIAGNOSTIC TESTS (X-RAY/MRI) FOR THIS PROBLEM?

☐ No ☐ Yes—

WHERE DID YOU HAVE THIS TEST? _____

MARK ON THE FIGURE THE AREAS WHERE YOU ARE EXPERIENCING YOUR SYMPTOMS



WHAT IS YOUR

HEIGHT_____

WEIGHT_____

WHEN WAS YOUR LAST PHYSICAL EXAM?

WHAT IS OR WAS YOUR OCCUPATION?

DO YOU ENGAGE IN ANY EXERCISES BEYOND NORMAL DAILY ACTIVITIES AND CHORES?

☐ No ☐ Yes--DESCRIBE EXERCISE & FREQUENCY:

WHAT ARE YOUR GOALS FOR THERAPY?

1.

2.

3.

MEDICAL SCREENING

MAKE A CHECKMARK (✓) IN BOXES APPROPRIATE FOR YOUR RESPONSE

IN PAST 3 MONTHS, HAVE YOU HAD/EXPERIENCED A CHANGE IN YOUR OVERALL HEALTH?

☐ No ☐ Yes--EXPLAIN:

IN PAST 12 MONTHS, HAVE YOU EXPERIENCED ANY FALLS?

☐ No ☐ Yes--EXPLAIN:

LIST ANY MAJOR SURGERIES

HAVE YOU EVER BEEN DIAGNOSED WITH OR BEEN TOLD YOU HAVE ANY OF THE LISTED CONDITIONS...

Cancer? ☐ No ☐ Yes
Explain: .....
Diabetes? ☐ No ☐ Yes
High blood pressure? ☐ No ☐ Yes
Heart disease/Attack? ☐ No ☐ Yes
Angina/chest pain? ☐ No ☐ Yes
Congestive Heart Failure? ☐ No ☐ Yes
Stroke/TIA? ☐ No ☐ Yes

LIST ANY PRESCRIPTION MEDICATIONS AND OVER-THE-COUNTER MEDICATIONS YOU ARE TAKING OR ASK OFFICE STAFF TO COPY YOUR LIST:

DO YOU HAVE...

Pacemaker/ICD? ☐ No ☐ Yes
Blood Clot/DVT? ☐ No ☐ Yes
Osteoarthritis? ☐ No ☐ Yes
Where: .....
Osteoporosis/Bone loss? ☐ No ☐ Yes
Fractures (broken bones)? ☐ No ☐ Yes
Where: .....
Fibromyalgia? ☐ No ☐ Yes
Headaches/Migraine? ☐ No ☐ Yes
Rheumatoid Arthritis? ☐ No ☐ Yes
Asthma? ☐ No ☐ Yes
COPD? ☐ No ☐ Yes
Emphysema? ☐ No ☐ Yes
Parkinson's disease? ☐ No ☐ Yes
Multiple Sclerosis? ☐ No ☐ Yes
Head Injury/TBI? ☐ No ☐ Yes
Seizures? ☐ No ☐ Yes
Depression/Anxiety? ☐ No ☐ Yes
Neuropathy (Numbness in extremities)? ☐ No ☐ Yes
Kidney/Bladder disease? ☐ No ☐ Yes
Gastrointestinal Problems? ☐ No ☐ Yes
High cholesterol? ☐ No ☐ Yes

WHAT IS YOUR CURRENT STRESS LEVEL?

☐ None ☐ Moderate ☐ High

DO YOU HAVE A LATEX ALLERGY?

☐ No ☐ Yes

FOR WOMEN ONLY

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?

☐ No ☐ Yes

NOTE: To optimize therapy results, our practice is to discontinue your therapy after two (2) cancellations and/or no-shows that are not made 24 hours prior to your appointment.

SIGNATURE OF: ☐ PATIENT ☐ PARENT ☐ AUTHORIZED PARTY	DATE
REVIEWED BY THERAPIST - SIGNATURE / TITLE	DATE