SSM Physical Therapy
A Service of SSM Rehabilitation Hospital

Patient Name: _____

Account Number: _____

**Outpatient Medical History/Screening Form**

**To be completed by the patient**

Patient Name:_____ DOB:_____

Religious/Cultural Needs: NO ☐ YES ☐ Please Explain:_____

Ethnicity:_____

Special Learning Needs: NO ☐ YES ☐ Please Explain:_____

Spoken Language: _____ Prefered language for health care information: _____

How did the pain / injury occur? _____

Have you had X-rays / MRI for this condition?

**Medical Information:**

PLEASE CHECK YES OR NO

| | YES | NO |
|---|---|---|
| Hypertension/High Blood Pressure | ☐ | ☐ |
| Hypotension/Low Blood Pressure | ☐ | ☐ |
| Light-Headedness / Dizziness | ☐ | ☐ |
| Emphysema/Asthma/Short of Breath | ☐ | ☐ |
| Bleeding / Bruising (recent history) | ☐ | ☐ |
| History of : diabetes | ☐ | ☐ |
| tumors / growths | ☐ | ☐ |
| Swelling Of Extremities | ☐ | ☐ |
| Active seizure disorder | ☐ | ☐ |
| Hypoglycemia /Low Blood Sugar | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ |
| Recent Fractures: | ☐ | ☐ |
| DATE:_____ AREA:_____ | | |
| Joint Replacement | ☐ | ☐ |
| DATE:_____ AREA:_____ | | |
| Alzheimers | ☐ | ☐ |
| Anxiety / Panic Attacks (recent) | ☐ | ☐ |
| Depression (recent) | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| Skin Sensitivity | ☐ | ☐ |
| Diminished Sensation/Numbness | ☐ | ☐ |
| Are you currently pregnant? | ☐ | ☐ |
| Arthritis / Rheumatoid Arthritis | ☐ | ☐ |
| Blood Borne Disease: | | |
| Hepatitis B / C / HIV / AIDS | ☐ | ☐ |
| Pacemaker | ☐ | ☐ |
| Cardiovascular disease: | | |
| Chest Pain /Angina /MI /CHF | ☐ | ☐ |
| Neurological Disease: | | |
| Brain Injury / MS / stroke / SCI | ☐ | ☐ |
| Urinary Urgency / Incontinence | ☐ | ☐ |
| Cancer- present or past | ☐ | ☐ |
| type & location: | | |
| Are you in pain? | ☐ | ☐ |

(0/10 =no pain 10/10 =worst pain imaginable)

Least amount of pain: ____/10

Worst amount of pain: ____/10

Other medical conditions not listed? _____

| | Yes | No |
|---|---|---|
| **If you answered yes to any of the above, are you under the care of a doctor for the condition?** | ☐ | ☐ |

**Allergies:** _____

**Recent or relevant Surgery(s) -** Include Dates: _____

**What are your therapy goals?**:_____

**If you need information regarding Advanced Directives, please request information regarding Advanced Directives from the registration staff.**

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| **FALL RISK ASSESSMENT*:** | YES | NO |
|---|---|---|
| Have you fallen within the last year? If so, how many times? _____ | ☐ | ☐ |
| Have any of these falls resulted in an injury within the last year? | ☐ | ☐ |
| Are you afraid of falling? | ☐ | ☐ |
| Have you recently felt unsteady on your feet or in your wheelchair? | ☐ | ☐ |
| Do you experience dizziness or vertigo? | ☐ | ☐ |
| Do you have vision problems that are not corrected by glasses? | ☐ | ☐ |
| Do you use sedatives that affect your level of alertness during the day? | ☐ | ☐ |
| Do you have memory / cognitive difficulties? | ☐ | ☐ |
| Do you have a lower extremity medical disability that affects walking? | ☐ | ☐ |

**AS PER CMS FALL SCREENING CRITERIA**

***Patient is considered a fall risk if patient has fallen two or more times in the past year**

***Patient is considered a fall risk if patient has fallen one time with resulting injury in the past year**

| **NUTRITIONAL SCREENING** | YES | NO |
|---|---|---|
| Unexplained weight loss? (>5% in last 30 days) | ☐ | ☐ |
| A recent loss of appetite/ aversion to food? | ☐ | ☐ |
| Do you have difficulty swallowing? | ☐ | ☐ |
| A significant decrease in food intake (<50% for 3+ days) | ☐ | ☐ |
| Are you under the care of a MD for these conditions? | ☐ | ☐ |

**CURRENT MEDICATION: (List below or copy enclosed)**

Are all meds prescribed by a physician? Yes ☐ No ☐

Reviewed / Updated (date and initials)

**PATIENT SIGNATURE:**_____ **DATE:**_____

If signature other than patient, relationship to patient (guardian or parent if minor) :_____

**To be completed by evaluating Therapist**

* ***FALL RISK*** *- Based on the therapist's judgement, a patient can be considered a fall risk if they answer yes to three or more fall risk assessment questions, or if they meet CMS screening criteria for fall risk. Clinician should issue Home Safety brochure if appropriate.*

Patient has been identified as a fall risk : yes no

If yes, fall prevention program has been implemented: yes no

**Therapist Signature:** **Date:**

(Therapist has reviewed medical history form with patient)