Patient Name:______________________
Account number:____________________

SSMHealth
Physical Therapy
A service of SSM Health Rehabilitation Hospital

Outpatient Medical History / Screening Form - pg.1 of 2

To be completed by the patient

Patient Name:_________________________________ Spoken Languages:_____________________________

Preferred language to receive healthcare information *for patient*:______________________________

Preferred language to receive healthcare information *for legal guardian / Healthcare Proxy*: ________________________

Emergency Contact:_____________________________ Telephone #:______________________________

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

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

Why are you here?________________________________ Date of Injury

Medical Information:

	YES	NO	Family History Y	Family History N
History of Diabetes	☐	☐	☐	☐
Hypertension (high blood pressure)	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Smoking	☐	☐		
Chest Pain / Angina	☐	☐		
Light-Headedness / Dizziness / Fainting	☐	☐		
Hypotension (low blood pressure)	☐	☐		
Shortness of Breath	☐	☐		
Ankle Swelling	☐	☐		
Night Coughing	☐	☐		
Cancer / Tumors / Growths	☐	☐	☐	☐
*Radiation / Chemotherapy Treatment	☐	☐		
Osteoporosis	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐
Have you had / have a: Stroke	☐	☐	☐	☐
Multiple Sclerosis	☐	☐		
Brain Injury	☐	☐		
Spinal Cord Injury	☐	☐		

Fractures
DATE:_________AREA:_________
DATE:_________AREA:_________
Joint Replacement
DATE:_________AREA:_________

	YES	NO
Diminished Sensation / Numbness	☐	☐
Skin Sensitivities:	☐	☐
Latex ☐ / Adhesives ☐ / Temperature ☐		
History of pressure sores	☐	☐
Pacemaker / Defibrillator	☐	☐
Bleeding / Bruising (recent history)	☐	☐
Hypoglycemia	☐	☐
Active seizure disorder	☐	☐
Dementia / Alzheimer's	☐	☐
Kidney Disease	☐	☐
Asthma	☐	☐
* Always have inhaler with you	☐	☐
Lung Disease / Emphysema / COPD	☐	☐
* Oxygen use	☐	☐
Are You Pregnant?	☐	☐
Blood Bourne Disease: Hepatitis B / Hepatitis C / HIV / AIDS	☐	☐
Anxiety / Panic Attacks (recent)	☐	☐
Depression (recent)	☐	☐

Other
____
____

In the past three months have you experienced:

	YES	NO
Changes or difficulty with Bowel	☐	☐
Changes or difficulty with Bladder	☐	☐
Night Sweats	☐	☐
Fever	☐	☐

Are you in pain?
Location of pain_______________________________
If you answered yes to any of the above:
Are you under the care of an MD for these conditions? YES ☐ NO ☐

Allergies: ____

Recent or relevant Surgery(s) - Include Dates:
____

What are your Rehabilitation goals?:____

Patient Name:____________________ Account Number:_____________________

Medical Information:

If you would like information regarding Advanced Directives, please request information from our registration staff.
Advanced Directives are not honored in the Outpatient Setting.

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 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)	☐	☐
Recent loss of appetite/aversion to food?	☐	☐
Do you have difficulty swallowing?	☐	☐
Decrease in food intake?(<50% for 3 days or more)	☐	☐
Are you under the care of a MD for these conditions?	☐	☐

CURRENT MEDICATION (List below)

I provided a separate list of medications:	☐
I am currently not taking any over the counter or prescribed medications / herbals:	☐

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

* ***FALL RISK*** *- Patient is considered a fall risk if they answer yes to three or more fall risk assessment questions, if they meet CMS screening criteria for fall risk, or if therapist judgment indicates. Clinician should issue Home Safety brochure if appropriate.*

Please inform your therapist of any changes in medications, medical conditions or surgeries so this summary list can be updated as you progress in your treatment.

PATIENT SIGNATURE:____**DATE:**_______________________

UPDATES:

Please list changes to Medication:

PATIENT SIGNATURE:____**NEW DATE:**_____________________

This information will be used as a guide to your treatment plan. If you need any medical follow-up, please contact your physician.

To be completed by evaluating Therapist

Patient has been identified as a fall risk: yes no

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

(Therapist has reviewed medical history form with patient)

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