SCERBO
PHYSICAL THERAPY & SPORTS REHABILITATION

725 River Road, Suite 60
Edgewater, NJ 07020
scerbopt.com

Office: 201.941.2240
Fax: 201.941.2250
Email: info@scerbopt.com

MEDICAL HISTORY | SCREENING FORM

Patient Name: _____ Spoken Language: _____

Emergency Contact: _____ Telephone Number: _____

Occupation: _____

Family Physician / Internist: _____ Telephone Number: _____

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

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

Medical Information: To the best of your knowledge, have you had or do you have:

	YES	NO		YES	NO
High Blood Pressure	■	■	Spinal Cord Injury	■	■
Chest Pain / Angina / Heart Attach	■	■	Traumatic Brain Injury	■	■
High Cholesterol	■	■	Stroke	■	■
Pacemaker	■	■	Fractures DATE: _____ AREA: _____ DATE: _____ AREA: _____	■	■
Emphysema / Asthma	■	■			
Shortness of Breath	■	■	Concussion	■	■
Fainting Disorders	■	■	Osteoporosis	■	■
Hepatitis	■	■	Multiple Sclerosis / Parkinson's	■	■
Bleeding /Bruising	■	■	Swelling of Extremities	■	■
Anemia	■	■	Artificial Joints	■	■
Diabetes	■	■	Muscle Pain / Fatigue	■	■
Hypoglycemia	■	■	Light-Headedness /Dizziness	■	■
Cancer / Tumors / Growths	■	■	Night Pain	■	■
Blood Disorders	■	■	Night Sweats	■	■
HIV / AIDS	■	■	Are you Pregnant?	■	■
Seizures	■	■	Bladder / Bowel Incontinence	■	■
Anxiety / Panic Attacks	■	■	Other: _____	■	■
Depression	■	■		■	■
Kidney Disease / Stones	■	■	Height: _____ Weight: _____	■	■
Do you cough or choke when you drink or eat?	■	■	Under 18 y/o ONLY Immunizations Current	■	■

Pain:
Rate Your Pain: (0-10) (none) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

Location of Pain: _____

FALL RISK ASSESMENT:	YES	NO	NUTRIONAL SCREENING:	YES	NO
Have you fallen in the last six months?	■	■	Diarrhea/ Nausea/ Vomiting	■	■
Do you experience dizziness or vertigo?	■	■	Unexplained weight loss? (<5% in the last 30 days)	■	■
Are you afraid of falling?	■	■	Loss of appetite or aversion to food?	■	■
Have you recently felt unsteady on your feet? or in your wheelchair?	■	■	Decrease in food intake? (<50% for 3 days or more)	■	■
Do you have vision problems that are not corrected by glasses?	■	■	History of eating disorder?	■	■
Do you use sedatives that affect your arousal during the day?	■	■	Change in bowel habits?	■	■
Do you memory /cognitive difficulties?	■	■	CURRENT MEDICATION: (List Below)	■	■
Do you have a lower extremity disability that affects walking?	■	■	List attached: ■		

Allergies: A. To Medications: _____

B. To Other Substances: _____

Surgery (s) Include Dates: _____

X-Rays, MRI, CAT-Scan (Include Area & Date) _____

What are your treatment goals? _____

If you need information regarding Advanced Directives, please contact the site Admissions / Office Assistant.

PATIENT SIGNATURE: _____ DATE: _____

Relationship if other than patient / parent / guardian if minor: _____

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

For office use only

Patient has been identified as a fall risk: yes no (yes if patient answered yes to 3 or more fall risk questions above)
If yes, fall prevention program has been implemented: Yes ■ No ■
Patient has been identified as a nutrion risk: Yes ■ No ■ Physician has been notified: Yes ■ No ■
Patient has been identified as requiring social service referral: Yes ■ No ■

THERAPIST SIGNATURE: _____ DATE: _____

(Therapist has reviewed medical history form with patient)