SCERBO
PHYSICAL THERAPY & SPORTS REHABILITATION

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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 Attack	❑	❑	Traumatic Brain Injury	❑	❑
High Cholesterol	❑	❑	Stroke	❑	❑
Pacemaker	❑	❑	Fractures DATE: _____ AREA: _____	❑	❑
Emphysema / Asthma	❑	❑	DATE: _____ AREA: _____		
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)