



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:

Table with 4 columns: Condition, YES, NO, YES, NO. Rows include High Blood Pressure, Chest Pain / Angina / Heart Attack, High Cholesterol, Pacemaker, Emphysema / Asthma, Shortness of Breath, Fainting Disorders, Hepatitis, Bleeding / Bruising, Anemia, Diabetes, Hypoglycemia, Cancer / Tumors / Growths, Blood Disorders, HIV / AIDS, Seizures, Anxiety / Panic Attacks, Depression, Kidney Disease / Stones, Spinal Cord Injury, Traumatic Brain Injury, Stroke, Fractures, Concussion, Osteoporosis, Multiple Sclerosis / Parkinson's, Swelling of Extremities, Artificial Joints, Muscle Pain / Fatigue, Light-Headedness / Dizziness, Night Pain, Night Sweats, Are you Pregnant?, Bladder / Bowel Incontinence, Other, Height: Weight: 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:

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

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 follow-up please contact your physician.

<b>For office use only</b>
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 <input type="checkbox"/> No <input type="checkbox"/> Patient has been identified as a nutrition risk: Yes <input type="checkbox"/> No <input type="checkbox"/> Physician has been notified: Yes <input type="checkbox"/> No <input type="checkbox"/> Patient has been identified as requiring social service referral: Yes <input type="checkbox"/> No <input type="checkbox"/>

THERAPIST SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_