Holsman Physical Therapy & Rehabilitation P.C.

Outpatient Medical History / Screening Form

To Be Completed By The Patient / Family / Caregiver

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 # :______________________________

Family Physician / Internist:______________________________ Telephone # :______________________________

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

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

Hearing Difficulty: NO ☐ YES ☐ Speaking / Communication Difficulty: NO ☐ YES ☐

Why are you here?______________________________ Date of Injury:______________________________

Medical Information:

	Patient YES	Patient NO	Family History YES	Family History NO
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	☐	☐	☐	☐
Rheumatic Disease	☐	☐	☐	☐
Have you had / have a: Stroke	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐
Brain Injury	☐	☐		
Spinal Cord Injury	☐	☐		
Fractures:	☐	☐		

DATE:__________ AREA:______________________________

DATE:__________ AREA:______________________________

	YES	NO
Diminished Sensation / Numbness	☐	☐
Skin Sensitivities:	☐	☐
Latex ☐ / Adhesives ☐ / Temperatur ☐		
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?	☐	☐
In the past month, have you frequently been bothered by feeling down, depressed or hopeless?	☐	☐
In the past month, have you frequently been bothered by having little interest in things or have you lost pleasure in doing things?	☐	☐
Other:	☐	☐

____

____

In the past three months have you experienced:		
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: ______________________________

____

Surgery(s) within last 3 months - Include Dates: ______________________________

What are your Rehabilitation goals?______________________________

Medical Information:

If you need information regarding Advanced Directives, please contact the site Admission's Office Administrator. 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 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 refer to the Fall Prevention Policy in the OP KRC P&P manual (PC OP 1018).*

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:

Please list changes to medical condition / surgeries:

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

Patient has been identified as a nutrition risk : YES NO (If yes, notify MD)

Patient would benefit from a Social Services referral: YES NO (yes if therapist feels patient life is threatened / patient is a threat to others)

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

(Therapist has reviewed medical history form with patient)

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