Methodist Le Bonheur Healthcare

REHABILITATION SERVICES

OUTPATIENT MEDICAL SCREENING – Page 1 of 3

HISTORY:

Barriers to Learning: (Please select) ☐ Hearing ☐ Vision ☐ Cultural ☐ Religious ☐ Language

Explanation: _____

Accommodations: _____

Do you have a: Living Will? ☐ Yes ☐ No Durable Power of Attorney for Healthcare? ☐ Yes ☐ No

What is your primary reason for seeking Therapy today? _____

_____

Please describe your symptoms and when they began: _____

_____

What makes it better? _____

What makes it worse? _____

Have you been treated for this in the past? ☐ YES ☐ NO

If yes, when: _____ By whom? _____

What type of treatment has been performed? _____

What are you doing presently? _____

Do you currently do your own Wound Care: ☐ YES ☐ NO DOES NOT APPLY

If no, who assist you? _____

PAIN:

On a scale of 0 – 10 Please select your present level of pain: (0 = No Pain 10 = Severe Pain)

No Pain **Severe Pain**

0 1 2 3 4 5 6 7 8 9 10

Is There Any Radiating Symptoms? ☐ Yes ☐ No If yes, where? _____

Is There Any Numbness or Tingling? ☐ Yes ☐ No If yes, where? _____

Are Your Symptoms: ☐ Improving ☐ Getting Worse ☐ Unchanged

Pain Intensity: ☐ Minimal ☐ Moderate ☐ Maximal

Pain: ☐ Constant ☐ Intermittent Pain gets Worse with: _____

Pain gets Better with: _____

Is Sleep Interrupted Due to Pain? ☐ Yes ☐ No

Are You Taking Pain Medications to Sleep? ☐ Yes ☐ No

Any Previous Treatments / Therapies for This Condition? ☐ Yes ☐ No

If yes to any of the above questions, please describe: _____

_____

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OUTPATIENT MEDICAL SCREENING – Page 2 of 3

PLEASE SELECT THOSE HEALTH PROBLEMS THAT APPLY TO YOU:

HEAD
- ☐ Dizziness
- ☐ Frequent Headache
- ☐ Head Injury
- ☐ Eye Problems
- ☐ Seizures

NEUROMUSCULAR
- ☐ Stroke
- ☐ Contractures
- ☐ Spinal Cord Injury
- ☐ Loss of Feeling in Legs
- ☐ Parkinson's Disease

REUMATOLOGIC
- ☐ Arthritis
- ☐ Joint Pain / Swelling
- ☐ Redness of Joints
- ☐ Vasculitis
- ☐ Lupus

KIDNEY / BLADDER
- ☐ Kidney Disease
- ☐ Hemodialysis
- ☐ Problem Controlling Urine
- ☐ Urinary Tract Infection
- ☐

DERMATOLOGIC
- ☐ Skin Allergies
- ☐ Dermatitis
- ☐ Eczema
- ☐ Rashes
- ☐ Itching / Pruritus
- ☐ Scleroderma

ONCOLOGIC
- ☐ Cancer: Type: _____
- ☐ Location: _____
- ☐ Received Chemotherapy
- ☐ Received Radiation

GI
- ☐ Colitis
- ☐ Inflammatory Bowel Disease
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Problems Controlling Bowels

DIETARY
- Changes in weight greater than 10 lbs.
- ☐ Malnutrition
- ☐ Dehydration
- ☐ Decreased Appetite

CARDIOVASCULAR
- ☐ Angina
- ☐ Blood Clots
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Pacemaker
- ☐ Palpitations
- ☐ Swelling of Feet / Legs
- ☐ Varicose Veins

LUNG
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ TB (Tuberculosis)

HEMATOLOGIC
- ☐ Blood Thinning Medication
- ☐ Sickle Cell Disease
- ☐ Easy Bruising
- ☐ Phlebitis
- ☐ Anemia

MUSCULOSKELETAL
- ☐ Osteopenia
- ☐ Osteoporosis

MISCELLANEOUS
- ☐ Diabetes
- ☐ Type I - Insulin
- ☐ Type II – Diet Controlled
- ☐ Oral Medication
- ☐ Fasting Blood:
- ☐ Glucose Level:
- ☐ HIV / AIDS
- ☐ Hypothyroid
- ☐ Hyperthyroid

FAMILY HISTORY: (Please select) ☐ CANCER ☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐ TB (Tuberculosis) ☐ HEART DISEASE

☐ OTHER:_____

Do you smoke: ☐ Yes ☐ No If yes, How Long? _____ How Much? _____

If you stopped smoking, how long has it been since you last smoked? _____

Do you drink alcohol: ☐ Yes ☐ No If yes, how often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Socially

Do you exercise: ☐ Yes ☑ No If yes, describe: _____

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MEDICAL HISTORY - PROBLEM SUMMARY LIST

Date	Allergies/Adverse Reactions Include Food Allergies	Initials	Date	Allergies/Adverse Reactions Include Food Allergies	Initials

Date	Diagnosis/Surgeries/Conditions	Initials	Date	Diagnosis/Surgeries/Conditions	Initials

Date Start	Date Stop	Medications	Initials	Date Start	Date Stop	Medications	Initials

Initials	Name	Initials	Name