REPORT TITLE **Physical Therapy Clinic Medical History Screening Form** | DATE

What can your physical therapist help you achieve?

____

List any medications/ dietary supplements you are taking.

______________________________ ☐None

List any drug or latex allergies.

______________________________ ☐None

Do you have difficulties with? (Check all that apply)

☐Communication ☐Vision ☐None
☐Speech ☐Hearing ☐Other ____________

What is your primary language for healthcare?

☐English ☐Spanish ☐Other ____________

How do you learn best ?(Check one)

☐Seeing ☐Doing ☐Hearing

Are you: (Check *Yes* or *No*)

Pregnant? Potentially Pregnant / Nursing? ☐N/A ☐Y ☐N

Often bothered by feeling down, depressed or hopeless? ☐Yes ☐No

Often bothered by little interest or pleasure in doing things? ☐Yes ☐No

Do you: (Check *Yes* or *No*)

Feel safe at home and in the workplace? ☐Yes ☐No

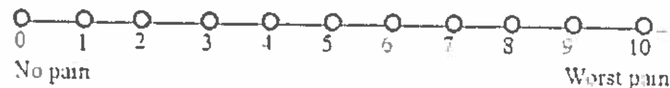
Use tobacco? ☐Yes ☐No
If yes, type ________, amount per day ______, for ______ years

Use alcohol? ☐Yes ☐No
If yes, ______ drinks per week

Rate your HIGHEST/WORST pain level in the past 72 hrs.

No pain — Worst pain

Rate your LOWEST/BEST pain level in the past 72 hrs.



No pain — Worst pain

Are your symptoms:

☐Getting worse? ☐Not Changing? ☐Getting Better?

Have you or any immediate family member ever been told you have: (Check *Yes* or *No*)

	Self		Family	
Cancer?	☐Yes	☐No	☐Yes	☐No
Diabetes?	☐Yes	☐No	☐Yes	☐No
High Blood Pressure?	☐Yes	☐No	☐Yes	☐No
Heart Disease?	☐Yes	☐No	☐Yes	☐No
Stroke?	☐Yes	☐No	☐Yes	☐No
Rheumatoid Arthritis?	☐Yes	☐No	☐Yes	☐No

Do you have a history of: (Check *Yes* or *No*)

Asthma/Bronchitis?	☐Yes	☐No
Chest Pain/Angina?	☐Yes	☐No
Headaches?	☐Yes	☐No
Kidney Disease?	☐Yes	☐No
Liver Disease?	☐Yes	☐No
Neurologic Disease?	☐Yes	☐No
Osteoarthritis?	☐Yes	☐No
Osteoporosis?	☐Yes	☐No
Pain with sexual intercourse?	☐Yes	☐No
Pain in the pelvic region?	☐Yes	☐No
Sexually Transmitted Diseases?	☐Yes	☐No
Seizures?	☐Yes	☐No
Prior Surgeries?	☐Yes	☐No

Other ____________________________

In the past 3 months have you experienced: (Check *Yes* or *No*)

A change in your general health?	☐Yes	☐No
Nausea/Vomiting?	☐Yes	☐No
Fever / Chills / Sweats?	☐Yes	☐No
Unexplained weight change (>10lbs)?	☐Yes	☐No
Numbness or Tingling?	☐Yes	☐No
Changes in your appetite?	☐Yes	☐No
Difficulty swallowing?	☐Yes	☐No
Changes in cough/sputum?	☐Yes	☐No
Shortness of breath?	☐Yes	☐No
Bowel / Bladder loss of control?	☐Yes	☐No
Infections of any sort?	☐Yes	☐No
Difficulty sleeping due to pain?	☐Yes	☐No
Unexplained Falls/Decreased balance?	☐Yes	☐No
Dizziness / Vertigo?	☐Yes	☐No

(Form continued on back side)

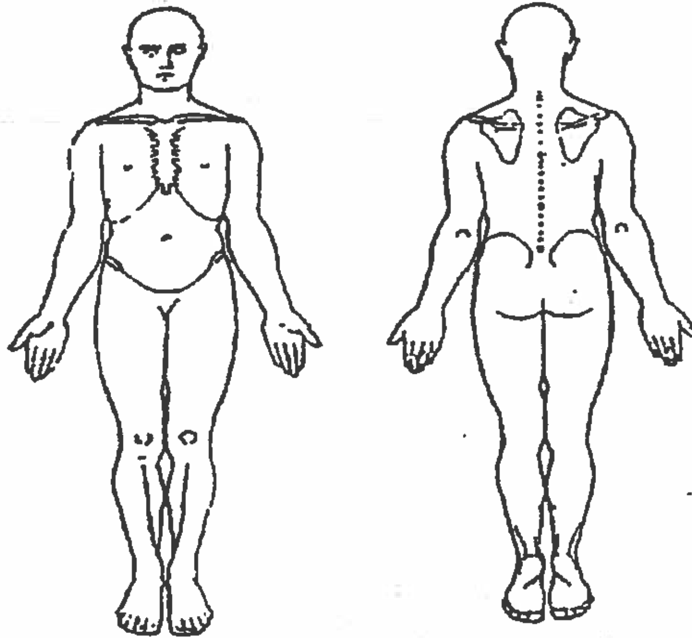
PATIENT IDENTIFICATION:

NAME (Last, First MI) ______________ GRADE or RANK ______________ UNIT: ______________

Last 4 # of Sponsor's SSN ______________ DOB (dd-mmm-yy) ______________ PHONE ______________

REPORT TITLE **Physical Therapy Clinic Medical History Screening Form** | DATE:

Mark on the body chart below where your pain is located and then describe what it feels like to you.



List 3 activities you have difficulty doing because of your pain.
Then on the scale below each activity, mark how difficult the activity is to perform.
(Example: running 1 mile—8)

Activity #1____

O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

No restrictions — Moderate difficulty — Unable to perform

Activity #2____

O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

No restrictions — Moderate difficulty — Unable to perform

Activity #3____

O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

No restrictions — Moderate difficulty — Unable to perform

MODIFIED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE[1]

Section 1: To be completed by patient _______AD ______Non-Active Duty

Name:_____________________________ Age:_______ Date:_________________

Occupation:___________________________ Number of days of back pain:____________(this episode)

Section 2: To be completed by patient

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in every day life. Please answer every question by placing a mark on the line that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the line which most closely describes your current condition**.

Pain Intensity

_____The pain is mild and comes and goes.
_____The pain is mild and does not vary much.
_____The pain is moderate and comes and goes.
_____The pain is moderate and does not vary much.
_____The pain is severe and comes and goes.
_____The pain is severe and does not vary much.

Personal Care (Washing, Dressing, etc.)

_____I do not have to change the way I wash and dress myself to avoid pain.
_____I do not normally change the way I wash or dress myself even though it causes some pain.
_____Washing and dressing increases my pain, but I can do it without changing my way of doing it.
_____Washing and dressing increases my pain, and I find it necessary to change the way I do it.
_____Because of my pain I am partially unable to wash and dress without help.
_____Because of my pain I am completely unable to wash or dress without help.

Lifting

_____I can lift heavy weights without increased pain.
_____I can lift heavy weights but it causes increased pain
_____Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned (ex. on a table, etc.).
_____Pain prevents me from lifting heavy weights off of the floor, but I can manage light to medium weights if they are conveniently positioned.
_____I can lift only very light weights.
_____I can not lift or carry anything at all.

Walking

_____I have no pain when walking.
_____I have pain when walking, but I can still walk my required normal distances.
_____Pain prevents me from walking long distances.
_____Pain prevents me from walking intermediate distances.
_____Pain prevents me from walking even short distances.
_____Pain prevents me from walking at all.

Sitting

_____Sitting does not cause me any pain.
_____I can only sit as long as I like providing that I have my choice of seating surfaces.
_____Pain prevents me from sitting for more than 1 hour.
_____Pain prevents me from sitting for more than 1/2 hour.
_____Pain prevents me from sitting for more than 10 minutes.
_____Pain prevents me from sitting at all.

OSWESTRY QUESTIONNAIRE, p. 2

Section 2 (con't): To be completed by patient

Standing

_____I can stand as long as I want without increased pain.
_____I can stand as long as I want but my pain increases with time.
_____Pain prevents me from standing more than 1 hour.
_____Pain prevents me from standing more than 1/2 hour.
_____Pain prevents me from standing more than 10 minutes.
_____I avoid standing because it increases my pain right away.

Sleeping

_____I get no pain when I am in bed.
_____I get pain in bed, but it does not prevent me from sleeping well.
_____Because of my pain, my sleep is only 3/4 of my normal amount.
_____Because of my pain, my sleep is only 1/2 of my normal amount.
_____Because of my pain, my sleep is only 1/4 of my normal amount.
_____Pain prevents me from sleeping at all.

Social Life

_____My social life is normal and does not increase my pain.
_____My social life is normal, but it increases my level of pain.
_____Pain prevents me from participating in more energetic activities (ex. sports, dancing, etc.)
_____Pain prevents me from going out very often.
_____Pain has restricted my social life to my home.
_____I have hardly any social life because of my pain.

Traveling

_____I get no increased pain when traveling.
_____I get some pain while traveling, but none of my usual forms of travel make it any worse.
_____I get increased pain while traveling, but it does not cause me to seek alternative forms of travel.
_____I get increased pain while traveling which causes me to seek alternative forms of travel.
_____My pain restricts all forms of travel except that which is done while I am lying down.
_____My pain restricts all forms of travel.

Employment/Homemaking

_____My normal job/homemaking activities do not cause pain.
_____My normal job/homemaking activities increase my pain, but I can still perform all that is required of me.
_____I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities (ex. lifting, vacuuming)
_____Pain prevents me from doing anything but light duties.
_____Pain prevents me from doing even light duties.
_____Pain prevents me from performing any job or homemaking chores.

Section 3: To be completed by physical therapist/provider

SCORE:__________ or __________% (SEM 11, MDC 16) **Initial** **FU _____weeks** **Discharge**

Number of treatment sessions:_______________ **Gender:** Male Female

Diagnosis/ICD-9 Code:____________________

[1] adapted from Hudson-Cook N, Tomes-Nicholson K, Breen A. A revised oswestry disability questionnaire. In: Roland M, Jenner J, eds. Back Pain: New Approaches to Rehabilitation and Education. New York: Manchester University Press; 1989. p. 187-204. [Prepared May 1999]

RADER PHYSICAL THERAPY

CLINIC POLICY

833-853-1392

Please carefully review the following guidelines concerning your scheduled visits at Andrew Rader USAHC Physical Therapy Clinic. Late cancellations and NO-SHOWS greatly impair our ability to provide the best care possible to our patients, increases wait times, slows each patient's rehabilitation progress and eliminates an appointment that could have been used by another patient. Each no-show costs the Rader PT Clinic approximately $70. Use your camera phone to take a picture of this sheet with the phone numbers on it.

1. If you cannot make your scheduled appointment, please call the PT Clinic or Central Appointments (855-227-6331) as soon as possible (preferably within 24 hours) of your appointment to **CANCEL**. This allows our team to schedule other patients into that appointment slot. Please be considerate to your fellow patients because an appointment missed by you is an appointment missed by TWO. If you do not contact the clinic prior to scheduled time, the clinic will be consider your failure as a **NO-SHOW**. It is important to ensure that your correct phone number is listed in DEERS.
2. If a patient no-shows 2 or more appointments within a consecutive 30-day period, his/her chain of command may be notified of the missed appointments. We may recommend a negative counseling for the missed appointment using the DA4856 on the back of this sheet. A comment will be placed in the patient's electronic medical record documenting the missed appointments.
3. Patients who **NO-SHOW** on **3** separate occasions without good cause will have future appointments discontinued, their chain of command notified, and may be referred back to their primary care provider. Also patients who **NO-SHOW** will be called and advised that future appointments may be discontinued. Patients may be allowed to schedule additional appointments only at the discretion of the Chief, Physical Therapy.
4. Please be courteous to other scheduled patients and arrive to your appointments on time. If you are more than 10 minutes late, your will be considered an **NO-SHOW** and may be rescheduled at the discretion of the NCOIC and the treatment team given potential conflicts with other established patient's appointments. If you are going to be late, please call the clinic ahead of time so that we can best accommodate you.

I have read and understand the Rader Physical Therapy Clinic Patient policy. Help us help you.

Patient's Signature:____ **Date:**________________

Patient's Name/Rank/Unit:____

Patient's Supervisor/1SG Phone # and/or email address:

____