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.

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst pain

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

0 1 2 3 4 5 6 7 8 9 10

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)

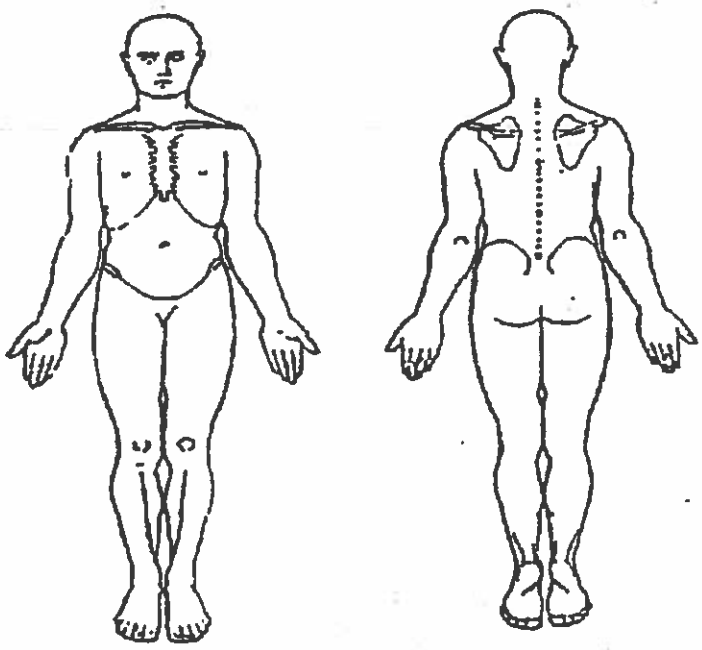
PATIENT IDENTIFICATION:

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

Last 4 # of Sponsor's SSN _____ DOB (Month/Day) _____ 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_____

0 1 2 3 4 5 6 7 8 9 10

No restrictions — Moderate difficulty — Unable to perform

Activity #2_____

0 1 2 3 4 5 6 7 8 9 10

No restrictions — Moderate difficulty — Unable to perform

Activity #3_____

0 1 2 3 4 5 6 7 8 9 10

No restrictions — Moderate difficulty — Unable to perform

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:

_____

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____/ 80

Please submit the sum of responses to ACN.

Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.