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*)

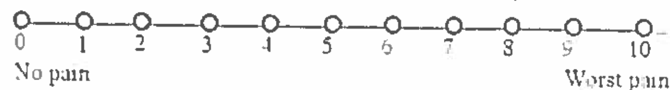
Feel safe at home and in the workplace? ☐Yes ☐No

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.

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



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)

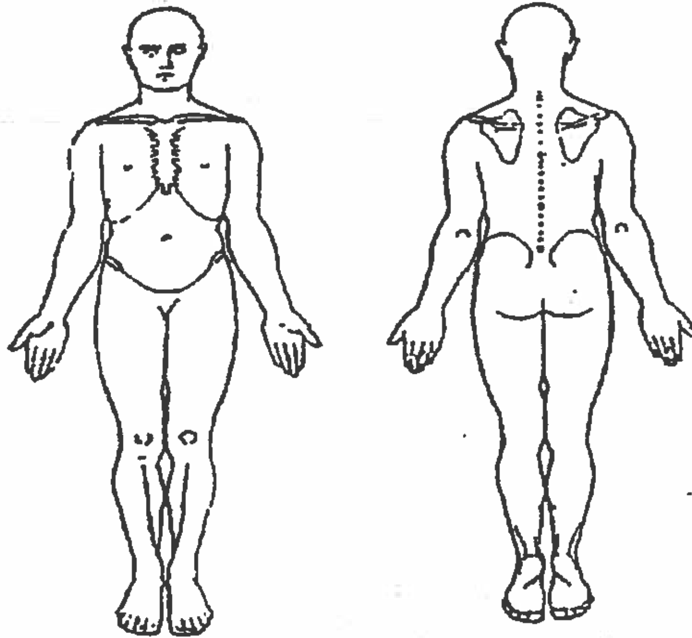
PATIENT IDENTIFICATION:

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

Shoulder Pain and Disability Index[1]

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

Name:______________________ Age:______ Date:______________

Occupation:______________________ Number of days of shoulder pain:__________(this episode)

Section 2: To be completed by patient

This questionnaire has been designed to give your therapist information as to how your shoulder pain has affected your ability to manage in every day life. For the following questions, we would like you to score each question on a scale from 0 (no pain) to 10 (worst pain imaginable) that best describes your shoulder over the past **WEEK**. Please read each question and place a number from 0-10 in the corresponding box.

Pain Scale: 0= No Pain 10=Worst Pain Imaginable

1.	At its worst?	
2.	When lying on the involved side?	
3.	Reaching for something on a high self?	
4.	Touching the back of your neck?	
5.	Pushing with the involved arm?	

Over the last **WEEK** how much difficulty did you have?

Disability Scale: 0= No Difficulty 10= So Difficult it Requires Help

6.	Washing your hair?	
7.	Washing your back?	
8.	Putting on an undershirt or pullover/sweater?	
9.	Putting on a shirt that buttons down the front?	
10.	Putting on your pants?	
11.	Placing an object on a high shelf?	
12.	Carrying a heavy object of 10 pounds?	
13.	Removing something from your back pocket?	

Section 3: To be completed by physical therapist/provider

SCORE:__________ **Initial** **F/U at ___ wks** **Discharge**

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

Diagnosis/ICD-9 Code:____________

[1] Adapted from Williams JW: Measuring function with the shoulder pain and disability index. J of Rheumatology 1995; 22:4: 727-32.

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:

____