Patient Acct #: _____
Provider Number:_____

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105 W 3rd St, Ponca, NE

● Rehab Screening/Confidential Medical History ●

Patient's Name: _____ Age:_____ Date: _____

Please complete the following questions to the best of your ability. This will help us to develop a treatment with you that meet your individual needs.

1. Date of injury when problem last caused you to seek medical attention:_____
2. Date of surgery _____ Have you received: X-ray MRI Bone Scan EMG Cat Scan Injections
3. How did your current problem begin? lifting twisting falling motor vehicle accident unknown other: _____
4. Were you hospitalized for this problem? yes no If yes, give dates: _____
5. Are you currently being seen by any of the following? dentist chiropractor osteopath physical therapist occupational therapist psychiatrist/psychologist
   If you are seeing any of the above, please describe the reason: _____
6. **Medicare patients: Have you had physical, occupational or speech therapy any time this year**?
   yes no If you answered yes, where? _____
7. Are you presently working? yes no. Occupation?_____
   If working, is it: light/modified duty regular duty?
8. Are you right or left handed?
9. Do you use a: cane walker other: _____ none
10. Do you live in a: 1-story home 2-story home Apartment other:_____
    Are there stairs present? yes no If yes, how many? ___ Is there a railing present? yes no
11. Do you have assistance in your home? spouse child family member caregiver friend
12. What type of exercise are you currently doing? _____
13. Do you currently experience any of the following? Cardiac Problems Diabetes Hypertension
    Other_____ Orthopedic Problems Rheumatoid Arthritis GI problems Cancer
    Seizures Multiple Sclerosis Fibromyalgia Depression Drug/Alcohol Dependency
14. Have you ever had a broken bone or fracture? yes no If yes, which body part: _____When:_____
15. Do you smoke? yes no If yes, number of packs/day? _____
16. Are you pregnant? yes no
17. List all prescription or over-the-counter medications you are currently taking:_____
18. Prior to this injury/surgery/condition, what was your level of function?_____
19. Now that you are experiencing this condition, what is your current level of function?_____
20. What makes your pain worse?_____
21. What makes your pain better?_____
22. What are your goals of therapy? _____