

NAME: _____ DATE OF BIRTH: _____ TODAY'S DATE: _____

In order to aid us in the selection of the proper treatment program, we ask that you complete the following health screening.

Do you have any of the following health conditions?

Rheumatoid Arthritis	Yes	No		Emphysema	Yes	No		Heart Problems	Yes	No
Osteoarthritis	Yes	No		Asthma	Yes	No		Cancer	Yes	No
Gout	Yes	No		Epilepsy	Yes	No		Mental Illness	Yes	No
Diabetes	Yes	No		High Blood Pressure	Yes	No		Head Injury	Yes	No

Have you experienced any of the following symptoms?

Stiffness or painful joints/muscles?	Yes	No		Swelling in the feet or ankles?	Yes	No
Headaches (frequent)?	Yes	No		Unusual bleeding?	Yes	No
Chest or jaw discomfort with exertion?	Yes	No		Easy bruising?	Yes	No
Buzzing or ringing in the ears?	Yes	No		Are you taking any blood thinner?	Yes	No
Dizziness?	Yes	No		Do you have a pacemaker?	Yes	No
Earaches (frequent)?	Yes	No		Do you have any metal implants?	Yes	No
Shortness of breath with exertion?	Yes	No		Are you pregnant?	Yes	No
				Do you smoke?	Yes	No

Please list any medications you are presently taking:

Medication	Dosage & Times per Day Taken	Medication	Dosage & Times per Day Taken

Do you have any allergies? YES NO If YES, please list _____

Have you undergone any surgical procedure other than what you are currently being evaluated for? YES NO If YES, please list _____

Are there any other conditions or symptoms for which you have or are currently being treated? YES NO If YES, please list _____

Has your physician ever indicated that you cannot exercise or perform other activities (i.e. jogging, swimming, lifting) or specified any job restrictions? YES NO If YES, please list _____

Have you received physical, occupational or speech therapy services in the **current calendar** year at another location/facility? YES NO If YES, please list _____

Patient's Signature

OVER

Therapist's Signature

Pain Rating Scale:

Instructions

Please rate your major area of pain on the 0 - 10+ Pain Rating Scale by writing the number of your pain, considering the work descriptors, at the present time and your best and worst over the past 30 days. Also, indicate the area where your pain is located and what type of Pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain which are **NOT** related to your present injury or condition.

Pain Rating	Now	_____
Over Past 30 Days	Best	_____
Over Past 30 Days	Worst	_____

Level of Pain:

10+	Maximal Pain
10	Very, Very Strong Pain
9	
8	
7	Very Strong Pain
6	
5	Strong Pain
4	Somewhat Strong Pain
3	Moderate Pain
2	Weak Pain
1	Very Weak Pain
.05	Very, Very Weak Pain

Areas of Pain:

///// Stabbing Pain

XXX Burning Pain

000 Pins and Needles Pain

=== Numbness

