SPECTRUM Physical Therapy & Athletic Training, LLC
Uniquely qualified to help patients break through physical barriers…

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Outpatient Medical History/Screening Form

Patient Name: _____ Spoken Language: _____
Emergency Contact: _____ Telephone #: _____
Family Physician/Internist: _____ Telephone #: _____
Religious/Cultural Needs: NO YES Please Explain: _____
Special Learning Needs: NO YES Please Explain: _____

Medical Information: To the best of your knowledge, do you have or have you had:

	YES	NO		YES	NO
High Blood Pressure	☐	☐	Spinal Cord Injury	☐	☐
Chest Pain/Angina/Heart Attack	☐	☐	Traumatic Brain Injury	☐	☐
High Cholesterol	☐	☐	Stroke	☐	☐
Pacemaker	☐	☐	Fractures	☐	☐
Emphysema/Asthma	☐	☐	DATE: _____ AREA: _____		
Shortness of Breath	☐	☐	DATE: _____ AREA: _____		
Fainting Disorders	☐	☐	Concussion	☐	☐
Hepatitis	☐	☐	Osteoporosis	☐	☐
Bleeding/ Bruising	☐	☐	Multiple Sclerosis / Parkinson's	☐	☐
Anemia	☐	☐	Swelling of Extremities	☐	☐
Diabetes	☐	☐	Artificial Joints	☐	☐
Hypoglycemia	☐	☐	Muscle Pain/ Fatigue	☐	☐
Cancer/ Tumors/ Growths	☐	☐	Light-Headedness/ Dizziness	☐	☐
Blood Disorders	☐	☐	Night Pain	☐	☐
HIV/ AIDS	☐	☐	Night Sweats	☐	☐
Seizures	☐	☐	Are You Pregnant?	☐	☐
Anxiety/ Panic Attacks	☐	☐	Bladder/ Bowel Incontinence	☐	☐
Depression	☐	☐	Other:	☐	☐
Kidney Disease/ Stones	☐	☐	Height: _____ Weight: _____		
Do you cough or choke when you eat or drink?	☐	☐	UNDER 18 ONLY: Immunizations Current	☐	☐

PAIN:

RATE YOUR PAIN: (0-10) _____

(none) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

LOCATION OF PAIN: _____

FALL RISK ASSESSMENT:	Yes	No	**NUTRITIONAL SCREENING:**	Yes	No
Have you fallen in the past 6 months?	☐	☐	Diarrhea/ Nausea/ Vomitting	☐	☐
Do you experience dizziness or Vertigo?	☐	☐	Unexplained Weight Loss? (>5% in last 30 days)	☐	☐
Are you afraid of falling?	☐	☐	Loss of appetite/ aversion to food?	☐	☐
Have you recently felt unsteady on your feet? Or in your wheelchair?	☐	☐	Decrease in food intake? (<50% for 3 days or more)	☐	☐
Do you have vision problems that are not corrected by glasses?	☐	☐	History of eating disorder?	☐	☐
Do you use sedatives that affect your arousal during the day?	☐	☐	Change in bowel habits?	☐	☐
Do you have a lower extremity Disability that affects walking?	☐	☐	**CURRENT MEDICATION: (List Below)** List Attached ☐		

Allergies: A. To Medications: _____

B. To Other Substances: _____

Surgery (S) Include Dates: _____

X-Rays, MRI, CAT SCAN (include Area & Date): _____

What are your treatment goals?: _____

If you need information regarding Advanced Directives, please contact the site Admission/Office Assistant.

PATIENT SIGNATURE: _____ **DATE:** _____

Relationship if other than patient/ parent/ guardian if minor: _____

This information will be used as a guide to your treatment plan. If you need any medical follow-up, please contact your physician.

For office use only

Patient has been identified as a fall risk: yes no (yes if patient answered yes to 3 or more fall risk questions above)
If yes, fall prevention program has been implemented: yes no
Patient has been identified as a nutrition risk: yes no Physician has been notified: yes no
Patient has been identified as requiring social service referral: yes no

SIGNATURE: _____ DATE: _____

(Therapist has reviewed medical history form with patient)