THE Portland Clinic

**Tigard Office**
9250 SW Hall Blvd.
Tigard, OR 97223

**PHYSICAL THERAPY DEPARTMENT**

# Rehabilitation 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 meets your individual needs.**

1. What is the reason for you visiting physical therapy?_____

2. Date of injury/illness or when problem last caused you to seek medical attention _____

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. Have you had physical/speech/occupational therapy since January of 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 ☐ Full-time ☐ Part-time

8. Are you ☐ Right Handed ☐ Left Handed Do you use a ☐ Cane ☐ Walker ☐ None ☐ Other _____

9. What type of exercise are you currently doing? _____

10. Do you currently experience any of the following? ☐ Cardiac Problems ☐ Diabetes ☐ Hypertension
    ☐ Orthopedic Problems ☐ Rheumatoid Arthritis ☐ GI Problems ☐ Cancer ☐ Seizures ☐ Multiple Sclerosis
    ☐ Fibromyalgia ☐ Depression ☐ Drug/Alcohol Dependency ☐ CVA/Stroke ☐ Change in appetite

11. Have you ever had surgery or a broken bone or fracture? ☐ Yes ☐ No
    If yes, which body part_____ When _____

12. Do you smoke? ☐ No ☐ Yes, number of packs/day? _____ Are you pregnant? ☐ Yes ☐ No

13. Your stress level of past 4 weeks – circle one No stress 0 1 2 3 4 5 6 7 8 9 10 High Stress

14. Living situation: ☐ Alone ☐ With other ☐ With assistance ☐ 1-story ☐ 2-story

15. List any medication allergies_____

16. List all prescription or over-the-counter medications you are taking for the problem you are being treated for today.

    _____

17. What are your goals for therapy?_____

Emergency Contact _____Phone Number_____

# Body Pain Chart

Are you experiencing pain due to your current accident or illness? ☐ Yes ☐ No

If you answered yes, indicate on the body diagrams where your pain occurs using the follow key:

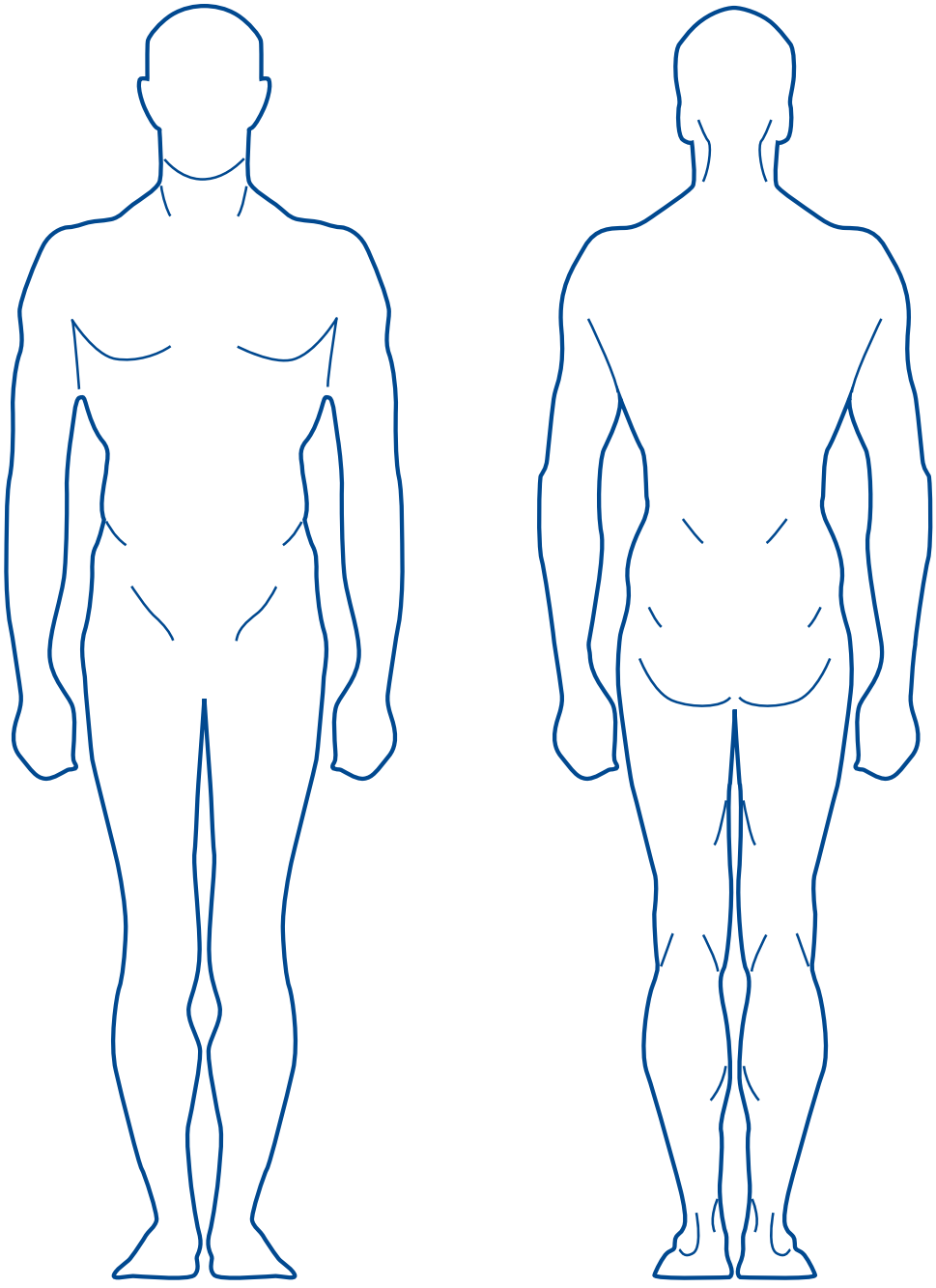
/// Stabbing

XXX Burning

OOO Pins & Needles

= = = Numbness

*** Aching



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# Functional Assessment Questionnaire

Patient's Name _____ DX _____

Using the key below please circle one answer in each box that indicates your ability to do the following activities,

**Key: (0 = unable) (1 = very difficult) (2 = moderately difficult) (3 = minimally difficult) (4= normal)**

| ACTIVITY | SCORE |
|---|---|
| Sleep normally | 0 1 2 3 4 |
| Up and Down Stairs | 0 1 2 3 4 |
| Food Prep/Cooking/Eating | 0 1 2 3 4 |
| Walking | 0 1 2 3 4 |
| Grooming (bath, comb hair, shave, etc) | 0 1 2 3 4 |
| Getting up/down from chair or bed | 0 1 2 3 4 |
| Dressing – manage normal dressing activities | 0 1 2 3 4 |
| Dressing – Tie Shoes/Button Shirt | 0 1 2 3 4 |
| Lifting/Carrying up to 10 pounds | 0 1 2 3 4 |
| Sitting for normal periods of time | 0 1 2 3 4 |
| Standing for normal periods of time | 0 1 2 3 4 |
| Reaching above head or across body | 0 1 2 3 4 |
| Leisure/Recreational/Sports Activities | 0 1 2 3 4 |
| Squatting down to pick up item | 0 1 2 3 4 |
| Running/Jogging | 0 1 2 3 4 |
| Driving | 0 1 2 3 4 |
| Job Requirements – can do all activities required of my job | 0 1 2 3 4 |

Rate your pain using the following scale, with 0 being no pain and 10 being very severe pain:

During Rest 0 1 2 3 4 5 6 7 8 9 10 During Activity 0 1 2 3 4 5 6 7 8 9 10

## CONSENT FOR TREATMENT

I hereby authorize the physical therapists at The Portland Clinic to perform the treatments or procedures approved by my referring physician.

I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

(Authorized Signature) _____ (Date) _____