Kansas Orthopaedic Center Physical and Hand Therapy
Rehabilitation Screening/Confidential Medical History

Patient's Name: _____ **Age:**____ **Date:** _____ **MRN #:**_____

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

1. Date of injury or when problem last caused you to seek medical attention:_____

2. How did your current problem begin? __ lifting __ twisting __ falling __ motor vehicle accident __ unknown __ other: _____

3. Were you hospitalized for this problem? ___ yes ___ no If yes, give dates:_____

4. Are you currently being seen by any of the following? __chiropractor __osteopath __ physical therapist __ occupational therapist __psychiatrist/psychologist
If you are seeing any of the above, please describe the reason: _____

5. **Medicare patients: Have you had physical, occupational, speech therapy or home health services any time in 2020?** ___ yes ___ no If yes, where?
_____

6. Are you presently working? __ yes ___ no. Occupation?_____
If working, is it____ light/modified duty ___ regular duty?

7. Are you ___right or ___ left handed?

8. Do you use a: ☐ cane ☐ walker ☐ other: _____ ☐ none

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

10. Do you currently experience any of the following?

☐ Cardiac Problems	☐ Diabetes	☐ Hypertension
☐ Orthopedic Problems	☐ Osteoarthritis	☐ GI problems
☐ Cancer	☐ Seizures	☐ Multiple Sclerosis
☐ Fibromyalgia	☐ Depression	☐ Drug/Alcohol Dependency
☐ Rheumatoid Arthritis		

11. Have you ever had a broken bone or fracture? ___ yes ___ no If yes, which body part:
_____ When:_____

12. Do you use tobacco? ___ yes ___ no If yes, how much? _____

13. Are you pregnant? ___ yes ___ no

14. How would you describe your overall health __ excellent __ very good __ good __ fair __ poor

15. List any medication allergies_____

16. List all prescription or over-the-counter medications you are currently taking **if you have not provided this information already:**
_____
_____
_____

17. Current living situation: __ live alone __ live with spouse/ family/friend __ live in assistant living

18. What are your goals of therapy? _____