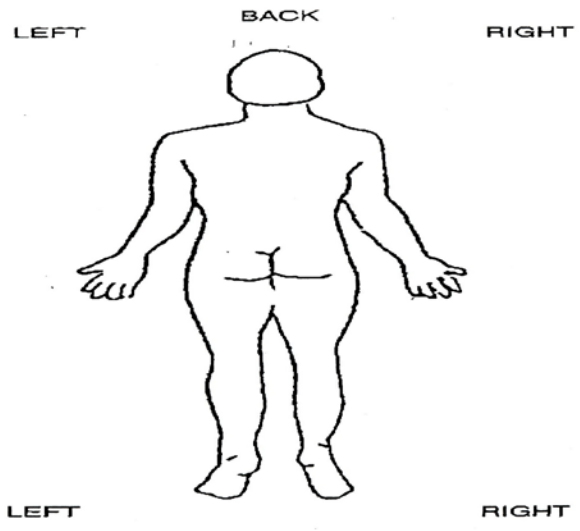
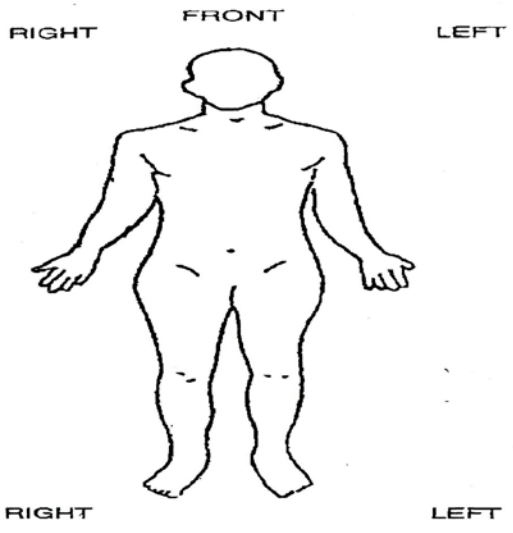
Rehabilitation Screening / Medical History

Patient's Name:_____DOB:_____Date:_____

*****Are you having any type of Home Health services for any reason including Physical Therapy, Nursing, Occupational Therapy, Speech Therapy or other Home Health Service? Yes☐ No☐**
If so please list:_____

1. Reason for this visit? _____
2. Date of injury 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. Have you fallen at least once in the past year and sustained an injury? Yes☐ No☐
   A) Have you fallen at least twice in the past year without an injury? Yes☐ No☐
5. Were you hospitalized for this problem? Yes☐ No ☐ If yes, give dates:_____
6. Are you currently being seen by any of the following? dentist☐ chiropractor☐ osteopath☐ physical therapist☐ occupational therapist ☐ home health☐
7. If you are seeing any of the above, please describe the reason:
   _____
8. What can you no longer do because of your current illness or accident?
   _____
9. Current living situation☐live alone ☐live with spouse/family ☐live in assistant living ☐other:
10. How would you describe your overall health☐excellent☐very good☐good☐fair☐poor
    Height?_____ Weight?_____
11. Are you experiencing pain due to your current accident or illness? Yes☐ No☐





12. Rate your pain using the following scale, with one being the least amount of 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

13. Have you had therapy for this recent illness? Yes☐ No☐ If you answered yes, please explain where and when and the outcome of the therapy:_____

_____

14. Are you presently working? Yes☐ No ☐ Occupation?_____

If working, what type of duty: light/modified duty☐ regular duty☐

15. Are you left handed☐ right handed☐ 16. Are you pregnant? Yes☐ No ☐

17. Prior to your current injury/illness, did you use a: cane☐ walker☐ other: _____none☐

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

19. How, if at all, have your exercise and daily activities changed due to your recent illness?

_____

20. Rate your stress level over the past 4 weeks: (circle)

No Stress ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 High Stress

21. Any recent significant change in your appetite? Yes☐ No ☐

22. 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

23. Have you ever had a broken bone or fracture? Yes☐ No ☐

If yes, which body part:_____ When:_____

24. Do you smoke? Yes☐ No☐ If yes, number of packs/day? _____

25. Please list current medications: _____

_____

26. Do you have any medication and/or latex allergies Yes☐ No☐ If answered yes please list:

_____

27. What goals would you like to achieve from therapy?_____

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Midwest Orthopaedic INSTITUTE

ATTENDANCE POLICY

Thank you for choosing MOI Human Motion Therapy to provide your rehabilitation care. It is our goal to provide you the best possible care and treatment for your injury. In order for you to reach your rehabilitation goals, prompt and regular attendance is essential. If you know you will not be able to attend your scheduled appointment, please inform us as soon as possible so we can accommodate other patients who need care. We request 24 hour notice if possible, and we will make an attempt to re-schedule your appointment. If you are late for your appointment, you may not receive your full treatment or you may need to be rescheduled.

Since regular, prompt attendance is vital to your recovery, it is our policy that habitual cancellations and/or non-attendance will result in your being discharged from therapy. A report will then be sent to your physician regarding your non compliance. Re-evaluation by your physician will be necessary to resume physical therapy. It is our policy that **3 cancellations in a one month may result in your being discharged as well as 2 consecutive no-shows.**

Thank you for your cooperation and we look forward to helping you achieve your rehabilitation goals.

I acknowledge receiving and understanding the above information and by signing below agree with the **Attendance Policy.**

SIGNATURE DATE:

***ABSOLUTELY NO CAMERAS OR VIDEO TAPING IN THE CLINIC**