EMORY
JOHNS CREEK
HOSPITAL

OUTPATIENT THERAPY SCREENING FORM
Patient Information:

Name:	Date of Birth:
Referring Physician:	Insurance:
Diagnosis for therapy & ICD code:	Date of Onset:
Your goals:	
Check one/all that apply: □ Working fulltime/part time □ Retired □ Permanently Disabled □ Plan to work	
Occupation:	Last date worked:
Are there cultural/religious/ethnic concerns or concerns about self/situation/ home environment? □ Yes □ No Please describe:	
Do you live alone? □ Yes □ No With whom do you live?	
Have you had therapy before? □ Yes □ No Dates of previous therapy:	
List all medications that you are currently taking including OTC drugs, herbs, holistic medications and treatments:	

Medical History: Check all that apply & include dates

□ Allergies	□ Falls
□ Anemia	□ Fractures
□ Arthritis – OA/ RA	□ HIV/AIDS, MRSA/VRE, Hepatitis
□ Bowel/Bladder Changes	□ Joint Replacement- hip / knee/ shoulder
□ Blood pressure issues	□ Osteoporosis
□ Cardiac Disease	□ Seizures
□ Chest pain/angina	□ Stroke
□ Cardiac Implants	□ Surgeries
□ Cancer	□ Sleeping problems
□ Diabetes	□ Thinking skills/memory deficits

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□ Dizziness/lightheadedness	□ Vascular - DVT's
□ Depression/anxiety	□ Other

Notify MD of a Yes to any of these:

Have you had a persistent/productive cough > 3weeks? □ Yes □ No
Have you had fever/night sweats/nausea or vomiting? □ Yes □ No
Have you had unintentional weight loss >10lbs □ Yes □ No

Check all that you are having difficulty with:

□ Communication □ Climbing stairs □ Computer use □ Chewing or swallowing □ Dressing
□ Driving □ Getting in/out of shower/tub □ Kneeling □ Memory □ Managing medication
□ Reading/writing □ Social conversation □Walking □ Other: _____

Miscellaneous Information:

How do you learn best? □ Pictures □ Listening □ Reading □ Demonstration □ Other:
How would your describe your routine day? □ Sedentary □ Active □ Very Active
Have you fallen in the past several months? □ Yes □ No Describe:
DME currently owned/rented: □ None □ BSC □ Cane □ Reacher/ hip kit □ Shower chair □ Wheelchair □ walker □ Speaking device
Are you pregnant or breast feeding? □ Yes □ No
Do you have non-healing wounds? □ Yes □ No

Pain Diagram:

Please use the symbols below to show the area, upon the body outlines, in which you are experiencing pain.
Ache-A Pins and Needles-P Burning-B Stabbing-S Numbness-N Other-O

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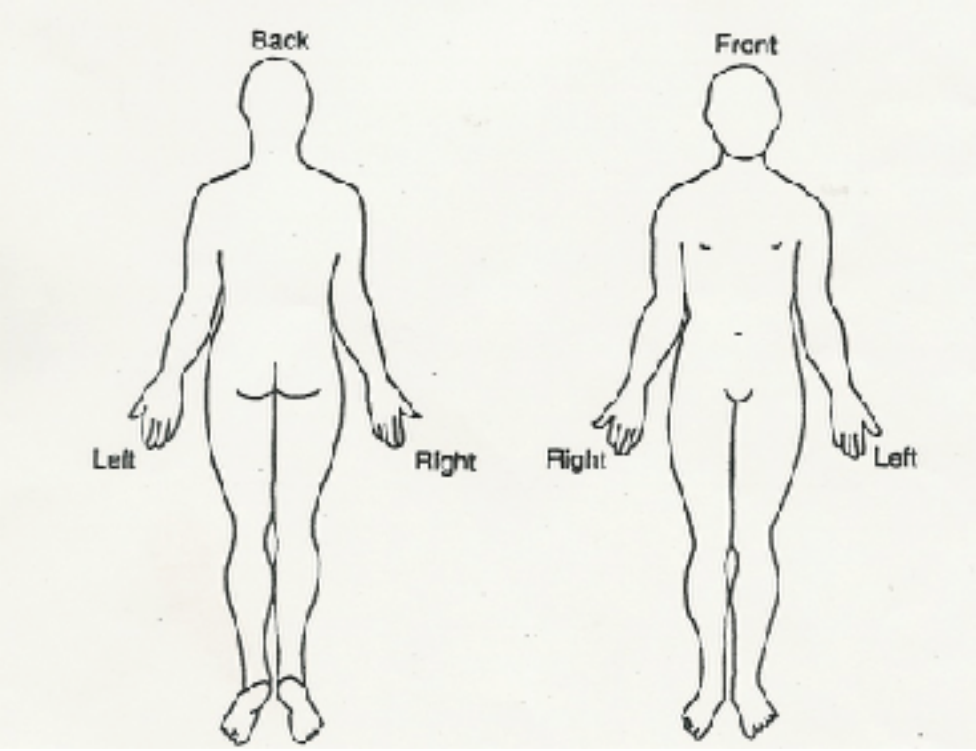

Check a number that describes the intensity of the pain from that describes your pain right now?
0 (none) to 10 (worst)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

If any of this information changes during your rehab stay please inform your therapist. This information will be added to the therapy treatment documentation.

Patient signature: _____ Date_____

(Revised 3/08/15)