Penn Medicine
Princeton Medical Center

Princeton Rehabilitation at Plainsboro

Self-Assessment/Medical History

Date: _____

Section 1: Patient Identifiers & Risk Factors

Smoker: YES NO Pacemaker: YES NO Latex Allergy/Sensitivity: YES NO
Pregnant: YES NO
How did you hear about us? _____
Emergency Contact & phone number: _____

Section 2: Medical History/Personal Factors (please circle any/all that apply)

□ Cancer (Type_____ Currently receiving treatment: YES NO)

□ Diabetes	□ Kidney Disease	□ Liver Disease	□ Stroke/CVA
□ Osteoporosis	□ Heart Disease	□ Angina/Chest pain	□ Lyme's Disease
□ Osteoarthritis	□ Rheumatoid Arthritis	□ HIV	□ Asthma
□ Anemia	□ C-Diff	□ COPD/Emphysema	□ Hepatitis
□ Concussion	□ High Blood Pressure	□ Parkinson's Disease	□ Seizure/epilepsy
□ Tuberculosis	□ Hepatitis	□ Lung Disease	□ Blood clots
□ Circulation Disorder	□ Thyroid Disease	□ Fibromylagia	□ Incontinence
□ Falls (how many in past year?) _____		□ Multiple Sclerosis	

□ Other: _____
Fracture (please specify body part & date): _____
Metal Implants (please list): _____
Relevant Surgeries that may impact care (please list type & date): _____
_____
Medications (please list): _____
_____
Are you currently taking medication for the issue that brings you in today? YES NO
Do you currently take steroids/have you been on steroid in the past? YES NO
Are you currently working? YES NO **Occupation/Employer**: _____
Have you had physical therapy in the past? YES NO Did it help (if yes): YES NO

Section 3: Body Structure/Functions (circle any that occurred in the past week):

□ Fever/chills/sweats	□ Recent falls/poor balance	□ Numbness/tingling
□ Dizziness	□ Headaches	□ Change in bowel/bladder
□ Nausea/vomiting	□ Fatigue	□ Shortness of breath
□ Increased pain at night/sleepless	□ Unexpected weight loss/gain	□ Change in appetite
□ Malaise	□ Muscle weakness	□ Change in mental status
□ Change in vision	□ Recent infection	□ Pulsating pain
□ Palpitations	□ Chest pain	□ Difficulty swallowing
□ Leg swelling		

(continued on other side)

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Are you experiencing any other symptoms that are not normal to you? _____
_____

Section 4: Current Symptoms

Date (approximate) of your injury, surgery, or onset of symptoms: _____
How did your symptoms occur? □ Car accident □ Work-related Injury □ Fall □ Trauma □ Surgery
□ Gradual onset □ Unknown □ Other _____
Have you had an X-Ray, MRI or any other diagnostic imaging done for this condition? YES NO

With 0 being none & 10 being the worst pain imaginable (emergency room pain) please rate your pain:
Best over the last 48 hours: _____ Worst over the last 48 hours: _____Current level: _____
My symptoms: □ Come & go □ Constant & unchanging □ Constant, varies with activity
My symptoms are: □ Getting better □ Remaining the same □ Getting worse
Have you received or are you currently receiving treatment for this condition? YES NO
(if yes please explain) _____

What makes your symptoms better?_____
What makes your symptoms worse? _____
My symptoms change (better or worse) with movement YES NO

Section 5: Social Screening

Over the past 2 weeks, have you felt "down" or depressed?	YES	NO
Over the past 2 weeks, have you felt little interest/pleasure in doing things?	YES	NO
Do you feel your quality of life is impacted because of this condition?	YES	NO

Section 6: Activity Limitation and/or Participation Restriction

What are your goals for physical therapy? _____
_____

I have completed this form to the best of my ability & the information is correct.

_____ _____
Patient's signature Date

I have reviewed this information with the patient.

_____ _____
Physical therapist's signature Date