GOOD SHEPHERD®

OUTPATIENT MEDICAL INFORMATION FORM
WITH SCREENING QUESTIONS

Today's Date:_____

Name:_____

MR#:_____

Account #:_____

GOOD SHEPHERD OUTPATIENT MEDICAL INFORMATION FORM WITH SCREENING QUESTIONS

Please complete all sections in full

Name:_____ Doctor who ordered therapy:_____

Date of Birth:____/____/____ Date of next scheduled Doctors appt:_____

Date of Last Physical:____/____/____ Family Medical Doctor (PCP):_____

Past Medical/Surgical History:

1. Check all that apply:

❒ Anxiety
❒ Arthritis
❒ Asthma
❒ Cancer
❒ Current Pregnancy
❒ Depression
❒ Diabetes
❒ Dizziness
❒ Headaches
❒ Heart Attack/Heart Disease/Pacemaker
❒ High Blood Pressure
❒ Incontinence bowel/bladder
❒ Liver/Kidney Disorder
❒ Lung Problems/Emphysema/COPD
❒ Metal Implants/Joint Replacements
❒ Osteoporosis/Osteopenia
❒ Seizures/Epilepsy
❒ Smoking __ppd __ yrs
❒ Stroke
❒ Work Related Injury
If checked, date of injury _____
❒ Other (please list)
_____
_____
_____
_____

2. Previous Hospitalization(s) (Please describe): _____

_____

3. Current medication(s) including over the counter, non-prescription drugs: _____

_____

4. Allergies (environment and/or medications):
❒ Latex ❒ Adhesive Tape _____

5. Recent tests (check all that apply): ❒ X-rays ❒ MRI ❒ Cat Scan ❒ Other _____
If so when? _____ **What were the results?** _____

In the past 3 months, have you experienced any of the following? (check all that apply)

A change in your health	❒ Yes	❒ No
Fever/chills/sweats	❒ Yes	❒ No
Change in skin/mole appearance	❒ Yes	❒ No
Shortness of breath	❒ Yes	❒ No
Urinary tract infection/Kidney stone	❒ Yes	❒ No
Nausea/vomiting	❒ Yes	❒ No
Unexplained weight change	❒ Yes	❒ No
Changes in appetite	❒ Yes	❒ No
Changes in bowel/bladder function	❒ Yes	❒ No
Any other new or unusual symptoms?	❒ Yes	❒ No

If yes, please explain:_____

History of Current Condition:

1. Briefly describe in your own words when your pain and/or symptoms began and what caused your current condition:
Onset Date:_____ **Cause:**_____

2. Are you currently receiving Home Care Services (nursing, physical or occupational therapy or home aide) at this time? ❒ Yes ❒ No

3. Have you had any previous therapy for this condition? ❒ Yes, When?_____ ❒ No

4. What are your goals of therapy? (i.e., decrease pain, return to sport/work, increase flexibility, increase strength, learn appropriate exercise to prevent re-injury, etc.)_____

5. Do you feel safe at home? ❒ Yes ❒ No If no, explain:_____

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Educational Needs:

1. **How do you best learn?**
   ❒ Pictures ❒ Reading ❒ Listening ❒ Demonstration ❒ Other_____
2. **Would you like nutritional counseling for your medical condition?** ❒ Yes ❒ No
   If yes, explain:_____
3. **Sexuality:** Do you have any questions or concerns about your current medical condition and how it affects your participation in sexual activities? ❒ Yes ❒ No ❒ Not Applicable
   If yes, explain:_____

Behavioral Health:

1. **This past week, have you had any thoughts that life was not worth living?** ❒ No ❒ Yes, if yes, describe:
   _____
2. **This past week, have you had any thoughts about hurting or even killing yourself?** ❒ No ❒ Yes, if yes, what have you thought about? _____
3. **Have you actually done anything to hurt yourself?** ❒ No ❒ Yes, if yes, describe:_____
4. **Are you under a doctor's care or crisis management for your mental health?** ❒ No ❒ Yes, if yes, what is the name of doctor/crisis center: _____

Pain Rating:

If you have pain, rate it on a scale from 0 → 10, with "0" being absolutely no pain and "10" being the most severe pain you can imagine, (i.e., in which you would need to go to a hospital). Mark the line at your pain level)

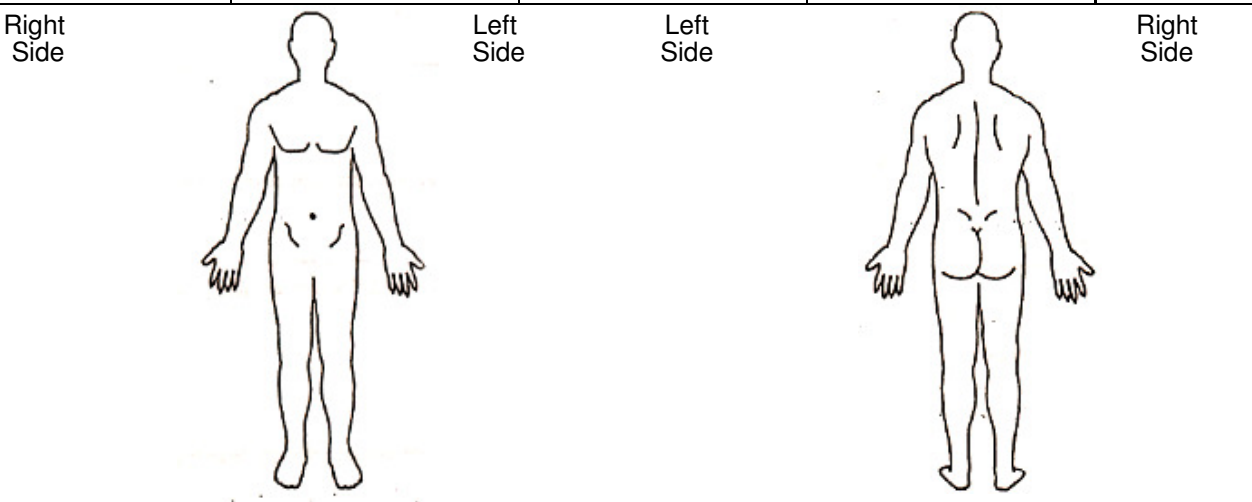
At worst _____ / 10
At best _____ / 10
Currently _____ / 10

If you have pain, indicate where your pain is located and what type you feel at the present time. Use the symbols below to describe your pain.

Do not indicate the areas which are not related to your present condition, injury or surgery.

KEY

/// Stabbing	XXX Burning	000 Pins and Needles	=== Numbness	... Aching



I understand that I have an active role in the development of my treatment plan. In order for me to receive the best care, my healthcare providers need an accurate picture and up to date medical history. As the patient, I understand that I am responsible for providing this information.

_____ _____

Signature Patient/Guardian Date