

Medical Screening Form Occupational Therapy

NAME: _____

RANK: _____ AGE: _____

Deployment Related: YES NO
Current Profile YES NO

1.) Are you (circle one):
Right-Handed Left Handed Both

2.) What problem brings you to the clinic today?

3.) When did your problem start?

4.) Check any of the following that apply to your problem:
 Had surgery Taking medicine Received an injection
 Given a splint to wear Had prior occupational therapy

5.) Are your symptoms?:
 Constant Intermittent Infrequent

6.) Prior to onset of your current problem, were you symptom-free in this area? Yes No

7.) Since onset, has your problem become:
 Worse Better Same

8.) Circle the current intensity of your discomfort:
 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
 (No discomfort) (Most severe)

9.) Describe your discomfort:
 Aching pain Sharp pain Shooting pain
 Burning Numbness Tingling
 Weakness Other (Please describe): _____

10.) What do you wish to accomplish in Occupational Therapy? (i.e. What activities do you want to get back to doing?):

11.) What is your job title?

Work Status:

Working/ Full duty Working/ Light Duty
 Working/ Limited Duty Not working
 Homemaker / Student

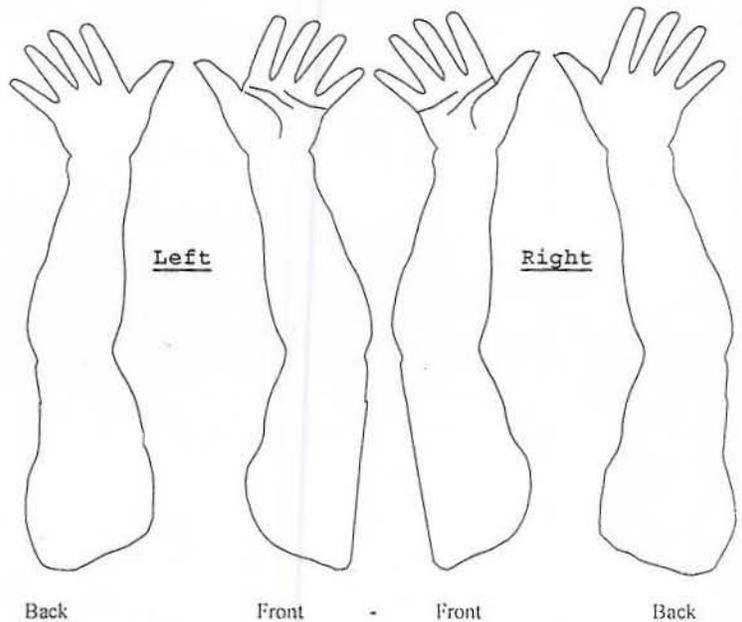
12.) Do you have any difficulty with:
 Hearing Vision
 Speech Communication

13.) I learn best by:
 Seeing Hearing
 Doing Combination

15.) Please list any medical conditions or precautions that we should know about:

16.) What is your primary leisure activity? (state if your injury/ illness affects your ability to participate):

Mark problem areas on the diagram below



Please check the activity that is difficult for you to perform

Dressing	<input type="checkbox"/>
Bathing	<input type="checkbox"/>
Grooming	<input type="checkbox"/>
Eating	<input type="checkbox"/>
Driving	<input type="checkbox"/>
Typing	<input type="checkbox"/>
Writing	<input type="checkbox"/>
Lifting	<input type="checkbox"/>
Carrying	<input type="checkbox"/>
Exercise	<input type="checkbox"/>
Housework	<input type="checkbox"/>
Hobbies	<input type="checkbox"/>
Childcare	<input type="checkbox"/>
Cold	<input type="checkbox"/>
Heat	<input type="checkbox"/>
Medication	<input type="checkbox"/>