FULL RANGE PT
& REHAB SERVICES
Your Life. Your Goals. Your Way.

Name: _____ **Date:** _____

Date of Birth: _____ **Email Address:** _____

For Patient to Fill out:

Medical History: Check each of the topics that relate to your medical history

□ Anemia □ A pacemaker □ Allergies □ Back Pain □ Angina □ Asthma □ Bronchitis □ Blot clot/Emboli
□ Bowel/bladder problems □ Drink alcohol □ Coronary heart disease □ Dizziness or faintness □ Gout □ Emphysema
□ Epilepsy/Seizures □ Hernia □ Hearing difficulties □ Heart attack □ Parkinson's □ High blood pressure
□ Kidney Disease □ Severe/frequent headaches □ Pneumonia □ Pregnant □ Stroke/TA □ Sleeping problems
□ Smoke Cigarettes □ Vision difficulties □ Thyroid problems □ Varicose Veins □ Women's health issues □ Weakness
□ Weight loss/energy loss □ Other: _____

Current Medications:

_____

What has prompted today's screening?:

_____

Pain level on a scale of 0-10 (0=no pain, 10=worst pain I've ever felt)

Current pain level? _____ Location: _____
What is your pain level at it's worst? _____ What makes it worse? _____
What is your pain level, when you feel best? _____ What makes it better? _____

For Clinician to Fill Out:

Vital Signs:

Blood Pressure (sitting): _____ Blood Pressure (standing): _____ HR: _____

Spine ROM Testing:

Cervical Spine

Flex: _____ Ext: _____ R Lateral Flex: _____ L Lateral Flex: _____
R Rotation: _____ L Rotation: _____
Additional Findings: _____

UE ROM Screen:

Shoulder:

Flex: _____ Ext: _____ Abd: _____ Add: _____ ER: _____ IR: _____
Additional Findings: _____

Elbow:

` Flex: _____ Ext: _____
Additional Findings: _____

Wrist:

Flex: _____ Ext: _____ Ulnar Dev: _____ Radial Dev: _____ Sup: _____ Pron: _____
Additional Findings: _____

UE Strength Screen:

Shoulder:

Flex: _____ Ext: _____ Abd: _____ Add: _____ ER: _____ IR: _____
Additional Findings: _____

Elbow:

` Flex: _____ Ext: _____
Additional Findings: _____

Wrist:

Flex: _____ Ext: _____ Ulnar Dev: _____ Radial Dev: _____ Sup: _____ Pron: _____
Additional Findings: _____

Recommendation:

Further evaluation for skilled care: ☐ Yes ☐ No

Statement/Reasoning for recommendation:

Plan: _____

- **Duration:** _____
- **Frequency:** _____

Clinician Signature: _____ **Date:** _____

Clinician Name: _____ **License Number:** _____

I have reviewed the above assessment and certify the plan of care.

Physician Signature:_____ **Date:** _____

Physician Name: _____ **NPI:** _____