



PERSONAL HISTORY & SOCIAL SERVICES SCREENING FORM

Name: _____ Date: _____

Referring Physician: _____ Date of injury: _____

History of injury to same area: _____

Did you have surgery? Yes No If yes, date of surgery: _____

PRESENT EMPLOYMENT:

Occupation: _____

Job duties: _____

Are you currently working? Yes No If no, off work since _____

Expected return date _____

PRIOR LEVEL OF FUNCTION:

What could you do before this episode of disability that you cannot do now?

Are you: Right Hand dominant _____ Left Hand dominant _____

Current Medications/allergies to medication:

MEDICAL CONDITIONS: Check any condition which you have or had

High blood pressure Bleeding disorder Heart disease Stroke Pace maker Epilepsy

Circulation disorder Ears-hearing aid Diabetes Allergies Eyes-glasses, contacts

Respiratory Pregnant Due date _____ Asthma Cancer Arthritis

Metal implants (Prosthetic, IUD, bullet)

Major Surgery Date(s)/Procedure(s) _____

Other: _____

SOCIAL HISTORY:

Do you consume alcoholic beverages? _____ Nicotine? _____ How often? _____

Describe home environment (multi story, multi step entry) _____

Do you have assistance available at home (spouse, child, other)? _____

SOCIAL SERVICES SCREEN (to be completed with therapist)

PATIENT REPORTS:

No social services intervention is necessary at this point in time

Social services evaluation is requested for current emotional/functional distress

THERAPIST ASSESSMENT:

No social services intervention is necessary at this point in time

Social services evaluation is requested for current emotional/functional distress

ACTION:

No intervention necessary Patient refuses social services evaluation

Referral to social services made

Patient signature

Date

Therapist signature

Date