**University Health Services**

 **Personal History & Social Services Screening Form** Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Referring Clinician**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date of injury\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Part of Body Injured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_History of injury to same area? \_\_\_\_\_\_\_\_

Did you have surgery? \_\_\_\_Yes \_\_\_\_No If yes, date of surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prior Level of Function:**

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you using an assistive device/ aide: \_\_\_Yes \_\_\_\_No. How many times per week do you normally exercise? \_\_\_\_\_\_

**Current Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies** (include medications, insect stings, food, etc.) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Conditions**

**\_\_**\_\_High Blood Pressure \_\_\_\_Fainting Spells \_\_\_\_Dizziness/Vertigo \_\_\_\_\_Exercise Intolerance \_\_\_\_Heart Disease **\_\_\_\_**Heart Murmur \_\_\_\_Pacemaker \_\_\_\_\_Circulation Disorder \_\_\_\_Stroke \_\_\_\_Epilepsy/Seizures\_\_\_\_Ears-Hearing Aid \_\_\_\_\_Bleeding Disorder \_\_\_\_Asthma \_\_\_\_Respiratory \_\_\_\_Cancer \_\_\_\_\_Diabetes

\_\_\_\_Eyes-Glasses/Contacts \_\_\_\_Anxiety \_\_\_\_Depression\_\_\_\_\_Mental Health Disorder \_\_\_\_Allergies \_\_\_\_Learning Barriers \_\_\_\_Pregnant-Due Date\_\_\_/\_\_\_/\_\_\_

\_\_\_\_Major Surgery \_\_\_\_Other

Please give surgery dates, procedures and “Other”\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social/ Personal History:**

Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hand dominance: Right \_\_\_\_\_\_\_\_\_ Left: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Enrollment level (freshman undergrad, graduate, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Course load (credits/ semester):\_\_\_\_\_\_\_\_

Currently Employed: Yes\_\_\_\_\_\_\_\_\_ No: \_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hours/ week: \_\_\_\_\_\_

Job duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Responsibilities (caregiver, etc):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Describe your home environment (multi-story, multi-step entry) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Factors that may limit your ability to participate in PT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consume alcoholic beverages? \_\_\_\_\_\_\_ How Often? \_\_\_\_\_\_\_\_\_\_ Nicotine? \_\_\_\_\_ How Often? \_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Report of Social or Additional Services Need**

Do you have any disabilities (temporary or permanent) requiring assistance with any of your daily tasks? \_\_\_\_\_\_\_\_\_\_\_\_\_

Are you or have you been in an abusive situation? \_\_\_\_\_\_\_ Do you currently need assistance regarding abuse? \_\_\_\_\_\_\_\_

**\_\_\_**\_ I do not request additional resources or social services evaluation at this time

\_\_\_\_ I do request additional resources for current emotional/functional distress

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical Therapist’s Assessment of Additional Services Recommendation**

\_\_\_\_ Personal factors reviewed and no social services and/or additional resources are currently recommended

\_\_\_\_ Personal factors reviewed and social services evaluation and/or additional resources are recommended

**Action:**

\_\_\_\_Recommendation made to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Patient declines additional resources

Therapist’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_