FSU | UNIVERSITY HEALTH SERVICES
DIVISION OF STUDENT AFFAIRS

Personal History & Social Services Screening Form

Medical Record # _____ 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
____Heart Disease
____Stroke
____Asthma
____Eyes-Glasses/Contacts
____Allergies
____Major Surgery
____Fainting Spells
____Heart Murmur
____Epilepsy/Seizures
____Respiratory
____Anxiety
____Learning Barriers
____Other
____Dizziness/Vertigo
____Pacemaker
____Ears-Hearing Aid
____Cancer
____Depression
____Pregnant-Due Date___/___/___
_____Exercise Intolerance
_____Circulation Disorder
_____Bleeding Disorder
_____Diabetes
_____Mental Health Disorder

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_____