Wheatlyn
235 Rosedale Dr.
Manchester, PA 17345
Phone: 717.812.7400
Fax: 717.268.0193

Deatrick Commons
16C Deatrick Dr.
Gettysburg, PA 17325
Phone: 717.339.2540
Fax: 717.337.2977

Adams Health Center
40 V-Twin Dr., Suite 101
Gettysburg, PA 17325
Phone: 717.339.2620
Fax: 717.339.2621

SPORT Center
207 Blooming Grove Rd.
Hanover, PA 17331
Phone: 717.632.3431
Fax: 717.633.5143

FUNCTIONAL CAPACITY EVALUATION PAPERWORK

This is a very comprehensive series of tests, which includes testing for strength, flexibility, lifting, pushing, pulling, carrying, bending and other work activities. This test takes up to 6 hours so it is very important that you be here on time. Due to the length and nature of the evaluation, we do not permit children, family members or acquaintances to observe the evaluation. An interpreter is permitted.

We also strongly suggest you eat breakfast or lunch on the evaluation day. Please avoid drinking any beverages containing caffeine (coffee, tea, soda) or smoking 2 hours prior to the evaluation as this elevates blood pressure and heart rate. A resting heart rate and blood pressure will be taken prior to the evaluation, and if the readings are too high, then the evaluation will not be completed.

You should dress casually in loose fitting clothes and comfortable shoes, no sandals or open-toed shoes or heels. If you are required to wear special shoes, clothes, tool belts, etc., for your job, please bring these items with you to help us more accurately test to your occupational demands.

Please take your medications as prescribed on the day of the evaluation.

Please be sure to bring a prescription from your physician, a copy of your medical records and a job description if available.

You may be asked to read and complete a number of forms and questionnaires prior to or during your evaluation. If you are unable to read or speak English please bring someone with you who can interpret for you.

IMPORTANT: If you must cancel your appointment please do so no later than 24 hours before your scheduled appointment. Failure to do so could result in a $200 cancellation fee being charged.

Since the Functional Capacity Evaluation can be very strenuous it is important we know of any heart conditions or problems prior to your participation in this evaluation. We ask that you answer the following questions regarding heart disease and bring them to your appointment. If you have answered yes to any of the questions, please contact the location you have been scheduled at. Failure to do so could result in the cancellation of your appointment. A positive response may require further physician approval before your participation in the Functional Capacity Evaluation.

1. Have you ever had a heart attack? YES or NO
2. Have you had heart surgery? YES or NO
3. Have you had an abnormal electrocardiogram? YES or NO
4. Do you have heart disease? YES or NO
5. Have you been told by a physician you have had angina? YES or NO
6. Have you been told by a physician you have had palpitations? YES or NO
7. Have you had a stroke? YES or NO
8. Are you pregnant? YES or NO
9. Do you have high blood pressure or have you ever been treated for high blood pressure (>150/95)? YES or NO
10. Are you currently being treated for any other medical condition? YES or NO

If you have any questions, please contact us at the number above. We are looking forward to meeting you and assisting you in your rehabilitation.

Sincerely,

Wellspan Rehabilitation

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INFORMATION/MEDICAL HISTORY

Name:_____ DOB:_____
Phone: (Home)_____ (Work)_____ (Cell)_____
Preferred DAYTIME contact # _____ Next appt with referring doctor_____

Current Conditions/Chief Complaint(s):
Why have you been referred for this evaluation? _____
_____
When did the problem begin (date)? _____
What happened? _____
Have you ever had the problem before? No_____ Yes _____
Please list any treatment you have participated in to manage your injury/symptoms (i.e. therapy, injections, medications, chiropractic care, etc).
_____
_____
How are you managing your symptoms now? _____
_____
What makes the symptoms worse? _____
Are you seeing anyone else for the problem(s)? No_____ Yes_____ (If yes, check all that apply.)

____Acupuncturist
____Physiatrist (Pain Mgmt)
____Orthopedist
____Primary Care Physician
____Internist
____Rheumatologist
____Other: _____
____Neurosurgeon
____Cardiologist
____Chiropractor
____Podiatrist
____Massage Therapist
____Neurologist

Please list all physicians that are currently involved in your health care:_____
_____

Clinical Tests:
Within the past year, have you had any of the following tests? (Check all that apply.)

____Angiogram
____Arthroscopy
____Blood Tests
____Bone Scan
____CT Scan
____Doppler Ultrasound
____Stress Test
____EKG
____EMG
____None of the above
____MRI
____Myelogram
____Nerve Conduction Study
____Pulmonary Function Test
____Spinal Tap
____Echocardiogram
____EEG
____X-rays
____Other: _____

Medications:
Do you take any prescription medications? No____ Yes ____ (If yes, please list any medications you are taking or provide a list we can copy.)_____
_____
Do you take any nonprescription medications? (Check all that apply.)

____Advil	____Aleve	____Naproxen
____Tylenol	____Aspirin	____Ibuprofen
____Decongestants	____Antacids	____Antihistimines
____Herbal Supplements	____Other:_____	

Have you ever had any adverse/allergic drug reactions? No____ Yes____ If yes, please describe reaction and which medication caused it. _____

Social History:

Marital Status:	____Single	____Married	____Divorced
Living Situation:	____Alone	____With Spouse	____With Children
	____Other:_____		

Are there any cultural or religious concerns that might affect your care? No____ Yes____
Are you aware of any learning problems that may affect your care? No____Yes____

Education:
____Highest grade completed (Circle one): 1 2 3 4 5 6 7 8 9 10 11 12
____Some college
____Technical school
____College graduate: Major_____
____Graduate school/advanced degree: Major_____

Functional Status/Activity Level: (Check all that apply) Do you have difficulty with any of the following:
____Rolling or getting in and out of bed
____Getting in and out of chairs/cars
____Walking on even surfaces
____Walking on uneven terrain
____Stair Climbing
____Bathing, dressing, grooming, toileting
____Household chores, shopping, driving/transportation, care of dependents
____Work
____Recreational/Leisure activity
____No difficulties noted

What positions do you have difficulty tolerating in order to complete daily activities?
_____
Please write what percentage (between 0% and 100%) of your normal activities you are now able to perform in the following areas (0%=not able to perform, 100%=able to perform all activities):

Leisure/Recreational Activities? ____% Home Activities?____% Work Activities?____% (If not currently working, rate based on job you were performing when you stopped working. Please do not leave blank.)

Social/Health Habits:

Smoking:
____Have never smoked
____Have quit smoking
____Smoke pipe/cigar only
____Smoke____packs a day

Alcohol:
____Never drink
____Seldom drink
____1 to 2 time(s) per week
____Daily (Quantity:_____)

Exercise:
Do you exercise beyond normal daily activities and chores? No____ Yes____
If yes, describe the exercise:_____
If yes, on average how many days per week do you exercise or do physical activity? _____ On an average day, for how many minutes? _____

Medical/Surgical History:

Please check if you have ever had:

____Arthritis	____Seizures/epilepsy	____Broken bones/fractures
____Osteoporosis	____Thyroid problems	____Heart problems
____Infectious disease	____High blood pressure	____Cancer
____Lung problems	____Kidney problems	____Stroke
____Repeated infections	____Diabetes	____Head Injury
____Stomach problems	____Hypoglycemia/low blood sugar	

____Other:_____
Please list any allergies you may have. _____

Within the past year, have you had any of the following symptoms? (Check all that apply.)

____Chest pain	____Difficulty sleeping	____Heart palpitations
____Loss of appetite	____Difficulty swallowing	____Shortness of breath
____Bowel problems	____Dizziness or blackouts	____Weight loss/gain
____Loss of balance	____Headaches	____Pain at night
____Joint pain or swelling	____Difficulty walking	____Vision problems
____Hearing problems	____Other:_____	

Have you ever had surgery? No____ Yes____
If yes, please describe and include dates: _____
_____

Vocational Information:

Are you currently receiving Workers' Compensation? No____ Yes____ If yes, please list
Insurance Company's Name:_____
Claims Adjuster's Name:_____
Rehab Nurse's Name:_____
Are you currently receiving any other disability benefits? No____ Yes____
Are you currently working? No____ Yes____ Retired____ Disabled____
If yes, are you currently working light duty? No____ Yes____
If you are currently off from work, please list the last date that you worked:_____
Employer's Name:_____
Contact person at company:_____
Job Title:_____

Briefly describe your normal job duties and the physical demands of your job:_____
_____
_____

Do we have your permission to leave a message on your answering machine? _____

The information provided in this questionnaire is correct to the best of my knowledge.

_____ _____
Signature of person completing form Relationship

Therapist Review (Signature and Date)

_____

IF THIS FORM IS NOT COMPLETED IN IT'S ENTIRITY AND BROUGHT TO YOUR APPOINTMENT, THE EVALUATION MAY HAVE TO BE RESCHEDULED.

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FUNCTIONAL PAIN SCALE

Please choose a pain level that best describes the functional effect of your pain. You can use half points if your pain is higher or lower than the descriptions.

10	**Worst Pain Possible:** Pain that brings on complete incapacitation and requires immediate emergency hospitalization.
8-9	Pain that causes you to cease the entire evaluation/treatment with the potential for seeking medical help.
7	**Severely disabling pain:** You are unable to move or use the affected area. You have difficulty concentrating on anything but the pain. You will need to leave the area or lie down with pain related tears.
6	Pain that begins to cause disability and you will need some time to recover before continuing.
5	**Very Limiting Pain:** Pain that causes great difficulty moving or applying strength through the painful area. You are unable to complete the current activity due to this pain.
4	**Functionally Limiting Pain:** Pain that begins to cause limits in your present functional abilities.
3	Pain that is starting to affect your ability to perform the current activity you are performing.
2.5 - 0.5	**Non-Limiting Pain:** You are experiencing pain but not at a level which would limit you from performing current activity
0	No pain or discomfort.

PAIN RATING: Pain Now_____ Best Day_____ Worst Day_____ (30 days)

Therapist:_____ Date:_____