

**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



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: _____

Do you take any prescription medications? No____ Yes ____ (If yes, please list any medications you are taking or provide a list we can copy.)_____

<u> </u> Advil	<u> </u> Aleve	<u> </u> Naproxen
<u> </u> Tylenol	<u> </u> Aspirin	<u> </u> Ibuprofen
<u> </u> Decongestants	<u> </u> Antacids	<u> </u> Antihistamines
<u> </u> Herbal Supplements	<u> </u> Other: _____	

Marital Status: Single Married Divorced
Living Situation: Alone With Spouse With Children
 Other: _____

____ 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 _____

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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Broken bones/fractures |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Infectious disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Repeated infections | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Hypoglycemia/low blood sugar | |
| <input type="checkbox"/> Other: <input type="text"/> | | |

Please list any allergies you may have.

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Heart palpitations |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Dizziness or blackouts | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain at night |
| <input type="checkbox"/> Joint pain or swelling | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Other: <input type="text"/> | |

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 listInsurance 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.**



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: _____