Roaring Fork Physical Therapy, P. C.

Social and Vocational Screening

Patient Name:_____ Date of Birth: _____

Diagnosis: _____ Today's date: _____

1. Are you currently receiving any social or vocational adjustment services? Yes No

   If you answered "yes" to the above, please list what provider you are seeing and why:

2. Are you able to take care of yourself in your home? Yes No

3. Are there any stressful events that currently affect your life?

a. Changes in employment	Yes	No
b. Death of someone close	Yes	No
c. Family Conflict	Yes	No
d. Inability to meet financial responsibilities	Yes	No
e. Major illness of family/friend	Yes	No
f. Recent move or relocation	Yes	No
g. Domestic abuse issues	Yes	No
h. Victim of a crime	Yes	No
i. Failing health	Yes	No
j. Other _____	Yes	No

   If you answered "yes" to any of the above, please describe:

4. In the past month, have you experienced any of the following?

a. Irritablility	Yes	No
b. Feelings of anxiety or panic	Yes	No
c. Loss of sleep or appetite	Yes	No
d. Hopelessness	Yes	No
e. Thoughts of harming yourself	Yes	No

5. Has your illness/injury affected you vocationally? Yes No
   If yes, please describe:

Social Worker's Review and Comments:

Social Worker's Signature:_____ Date:_____