Medical Screening Form

Name: _____ **Date:**_____ **Date of Birth:**_____

Occupation:_____ **Currently Working:** ☐ Yes ☐ No **Gender:** ☐ Male ☐ Female

Age:_____ **Weight:**_____ **Height:**_____ **BMI:**_____ **(we calculate)**

CURRENT CONDITION:

What is your reason for attending physical therapy? _____

_____

When did these symptoms start? Or what was the **date of injury/onset**? _____

How did this injury occur? ☐ Gradually ☐ Suddenly ☐ Injury Please describe:_____

_____

Have you ever had this problem before? ☐ Yes ☐ No If so, how was the problem treated?

_____

What makes your symptoms worse?

☐ Sitting ☐ Standing ☐ Walking ☐ Getting up from sitting position ☐ Exercise ☐ Stairs
☐ Bending/Squatting ☐ Driving ☐ Reading ☐ Working at home all day ☐ Being at work all day
☐ Other

If other, please describe: _____

What makes your pain better?

☐ Heating pad ☐ Ice pack ☐ Resting in bed ☐ Resting in chair ☐ Exercise ☐ Walking
☐ Medication ☐ Other

If other, please describe _____

Have you had any imaging studies done for this problem?

☐ X-Ray ☐ MRI ☐ Nerve Conduction ☐ Bone Scan ☐ CT Scan Date:_____

During the past month, have you noted little interest or pleasure in doing things? ☐ Yes ☐ No
Do you feel safe at home? ☐ Yes ☐ No
Have you ever been threatened, hit, or made to feel afraid by someone close to you? ☐ Yes ☐ No

Please turn over to next page

Past Medical History: Please Check any condition you currently have or have had in the past.

☐ Arthritis
☐ Osteoporosis
☐ Heart Disease/Problems
☐ High Blood Pressure
☐ Diabetes
☐ Stroke
☐ Rheumatoid Arthritis
☐ Angina
☐ Multiple Sclerosis
☐ Parkinsons
☐ Cancer
☐ Kidney Disease
☐ Liver Disease/Hepatitis
☐ Lung Disease/Problems
☐ Thyroid Problems
☐ Asthma/Allergies
☐ Fibromyalgia
☐ Depression
☐ Chemical Dependence
☐ Circulation/Bleeding Problems
☐ Pacemaker
☐ Metal Implants
☐ Other _____

Are you allergic to latex? ☐ Yes ☐ No Are you allergic to steroids? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No How many packs/day? __ For how many years? __ If quit, when? ____
Are you pregnant? ☐ Yes ☐ No

Currently, I am experiencing the following (check all that apply):

☐ Dizziness
☐ Unexplained Weight Loss
☐ Difficulty Swallowing
☐ Changes in Bowel/Bladder Function
☐ Increased Pain at Night
☐ Headaches
☐ Depression
☐ Fever / Chills / Sweats
☐ Nausea / Vomiting
☐ Shortness of Breath
☐ Changes in Appetite
☐ Numbness or Tingling
☐ Tremor
☐ Other _____

Have you fallen over the past 12 months? ☐ Yes ☐ No **If so, how many times?_____**

Are you currently taking any medications? ☐ Yes ☐ No
Please list ALL current medications (dosage / frequency) or provide a list:

1. _____ **4. _____**
2. _____ **5. _____**
3. _____ **6. _____**

Please list past surgeries with dates:

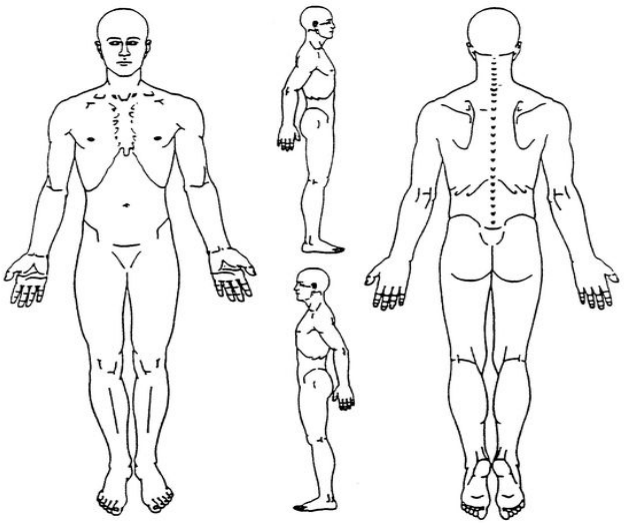
1. _____ **4. _____**
2. _____ **5. _____**
3. _____ **6. _____**

Please list any medical conditions you have that have not been documented above:

_____

_____

Shade in where you are in pain:



Circle the number that represents your ***average*** level of pain over the past week:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Circle the number that represents your ***worst*** level of pain over the past week:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Circle the number that represents your ***lowest*** level of pain over the past week:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Functional Limitations:

Identify up to 3 important activities that you are unable to do or have difficulty with as a result of your problem for which we are seeing you: 1._____

2._____

3._____

What are your therapy and/or fitness goals? Write out a goal or complete the sentence that applies to you. _____

☐ Decrease pain with _____

☐ Improve ability to_____

Are you currently physically active? ☐ Yes ☐ No

How many days per week do you exercise for at least 30 minutes:☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-7 ☐

Walking ☐ Biking ☐ Aerobics ☐ Exercise equipment ☐ Running

☐ Swimming ☐ Weight lifting ☐ Organized sports ☐ Other:

Emergency Contact:_____ ***Phone:***_____

Relationship to Patient:_____

Patient Signature: _____ ***Date:***_____