**Medical Screening Form**

To ensure you receive a complete and thorough evaluation, please provide the following important background information below. If you do not understand a question leave it blank and your physical therapist will assist you. Thank you.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Occupation:** |  |
| **Hobbies:** |  | **Allergies:** |  |

**Have you or anyone in your immediate family been diagnosed with any of the following conditions?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Self** | **Family** |  | **Self** | **Family** |
| Cancer | Yes | No | Yes | No | Asthma | Yes | No | Yes | No |
| Diabetes | Yes | No | Yes | No | Bronchitis | Yes | No | Yes | No |
| High Blood Pressure | Yes | No | Yes | No | Headaches | Yes | No | Yes | No |
| Heart Disease | Yes | No | Yes | No | Thyroid Issues | Yes | No | Yes | No |
| Stroke | Yes | No | Yes | No | Ulcers | Yes | No | Yes | No |
| Osteoporosis | Yes | No | Yes | No | GI Disease | Yes | No | Yes | No |
| Osteoarthritis | Yes | No | Yes | No | Seizures | Yes | No | Yes | No |
| Rheumatoid Arthritis | Yes | No | Yes | No | M.S. | Yes | No | Yes | No |
| Rheumatic Fever | Yes | No | Yes | No | Kidney Disease | Yes | No | Yes | No |

**Past Surgical History:**

Total joint replacements Yes No

 Spinal Surgeries Yes No

 Metal Implants (rods, pins, screws) Yes No

 Pacemaker Yes No

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In the past 3 months have you had or did/do you experience:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| A change in your health? | Yes | No | Difficulty Swallowing? | Yes | No |
| Nausea/Vomiting? | Yes | No | Changes in bowel or bladder function? | Yes | No |
| Fever/Chills/Sweats? | Yes | No | Shortness of breath? | Yes | No |
| Unexplained weight change? | Yes | No | Dizziness? | Yes | No |
| Numbness or tingling? | Yes | No | Upper respiratory infection? | Yes | No |
| Changes in appetite? | Yes | No | Urinary tract infection? |  Yes |  No |
|  |  |  |  |  |  |

**Have you fallen in the last year?**  Yes No

**If yes, how many times in the last 12 months? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Did you experience any injuries due to the fall?** Yes No

**If yes, please explain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Pregnant?** | Yes | No | **Depressed?** | Yes | No | **Under Stress?** | Yes | No |

**How are you able to sleep at night?** (Circle one)

|  |  |  |
| --- | --- | --- |
| Fine | Moderate difficulty | Only with medication |

**Do you have problems with:** (Circle **ALL** that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| Hearing | Vision | Speech | Communication |

|  |  |
| --- | --- |
| **Do you or have you in the past smoked tobacco?** Yes | No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | If yes, how many cigarettes a week? |  | Packs per year? |  |

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|  |  |
| --- | --- |
| **Do you drink alcoholic beverages?** Yes | No |

|  |  |  |
| --- | --- | --- |
|  | If yes, how many drinks do you have per week? |  |

|  |  |
| --- | --- |
| **Do you drink caffeinated coffee or beverages?** Yes | No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | If yes, how often?: | Monthly | Weekly | Daily |

**What brings you in for treatment?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Onset of Pain (circle one); Was there an:**

|  |  |  |  |
| --- | --- | --- | --- |
| Accident | Injury | Trauma (Violence) | Specific Activity |

|  |  |  |
| --- | --- | --- |
|  | If yes, describe: |  |

**Have you received any treatment for this problem in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**History of pain in this area?** Yes No

 If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Using the scale above, what is the pain at:**

 **Best** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Worst** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Today** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What other symptoms have you had with this problem? (Circle ALL that apply):**

|  |  |  |
| --- | --- | --- |
| Burning | Difficulty breathing | Hoarseness |
| Skin rash | Heart palpitations | Bleeding of any kind |
| Dizziness | Constipation | Tingling |
| Numbness | Vision changes | Cough |
| Joint Pain | Weight Change | Night Pain |
| Sweats | Weakness | Swallowing problems |

**Are there any other pain and/or symptoms of any kind anywhere else in your body that we have not talked about yet?** Yes No

|  |  |  |
| --- | --- | --- |
|  | If yes, describe: |  |

|  |  |
| --- | --- |
| **Date of last Physical Examination:** |  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Therapist Signature |  | Date |