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? _____

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

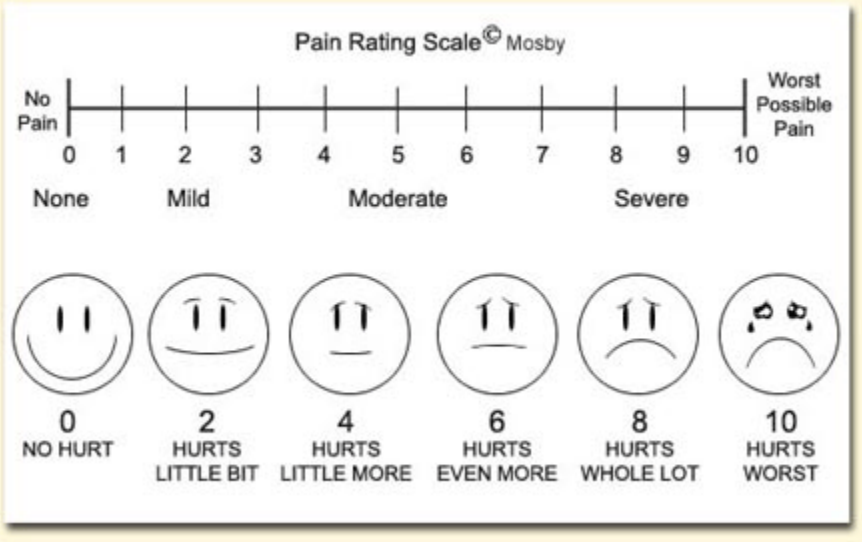
What brings you in for treatment? _____

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? _____



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