Physical Therapy Experts

Physical Therapy Medical Screening Questionnaire

Name:_____ **Date:** _____ **Age:** _____

Are you latex sensitive? D**Yes** D**No**

Do you smoke? D**Yes** D**No**

Do you have a pacemaker? D**Yes** D**No**

FOR WOMEN: Are you currently pregnant or think you might be pregnant? D**Yes** D**No**

ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

D fatigue	D numbness or tingling	D constipation
D fever/chills/sweats	D muscle weakness	D diarrhea
D nausea/vomiting	D dizziness/lightheadedness	D shortness of breath
D weight loss/gain	D heartburn/indigestion	D fainting
D difficulty maintaining balance while walking	D difficulty swallowing	D cough
D falls	D changes in bowel or bladder function	D headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

D cancer	D depression	D thyroid problems
D heart problems	D lung problems	D diabetes
D chest pain/angina	D tuberculosis	D osteoporosis
D high blood pressure	D asthma	D multiple sclerosis
D circulation problems	D rheumatoid arthritis	D epilepsy
D blood clots	D other arthritic condition	D eye problem/infection
D stroke	D bladder/urinary tract infection	D ulcers
D anemia	D kidney problem/infection	D liver problems
D bone or joint infection	D sexually transmitted disease/HIV	D hepatitis
D chemical dependency (i.e., alcoholism)	D pelvic inflammatory disease	D pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

D cancer	D diabetes	D tuberculosis
D heart problems	D stroke	D thyroid problems
D high blood pressure	D depression	D blood clots

During the past month have you been feeling down, depressed or hopeless? D**YES** D**NO**
During the past month have you been bothered by having little interest or pleasure in doing things? D**YES** D**NO**
If yes to either, is this something with which you would like help? D**YES** D**YES, but NOT today** D**NO**

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

_____

_____

Have you ever taken steroid medications for any medical conditions? D**YES** D**NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? D**YES** D**NO**
Please list any surgeries or other conditions for which you have been hospitalized, including dates:

_____

_____

What date (roughly) did your present problem start?_____

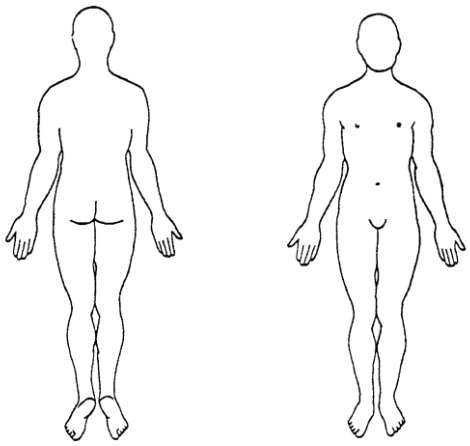
My symptoms are currently: D **Getting Better** D **Getting Worse** D **Staying about the same**

Treatment received so far for this problem (chiropractic, injections, surgery, etc): _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:



↓ **Shooting/sharp pain**
O **Dull/aching pain**
Ill **Numbness**
= Tingling

My symptoms currently: D Come and go D Are Constant D Are constant, but change with activity

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Circle your **current** level of pain while completing this survey: …0…1…2…3…4…5…6…7…8…9…10…

Circle the **best** your pain has been during the past 24 hours: …0…1…2…3…4…5…6…7…8…9…10…

Circle the **worst** your pain has been during the past 24 hours: …0…1…2…3…4…5…6…7…8…9…10…

Easing Factors: Identify **up to 3** important positions or activities that make your symptoms *better*:
1. _____
2. _____
3. _____

Aggravating Factors: Identify **up to 3** important activities that you are unable to do or are having difficulty with as a result of your problem.
1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?
D No problem sleeping D Difficulty falling asleep D Awakened by pain D Sleep only with medication

When are your symptoms worst? D Morning D Afternoon D Evening D Night D After activity
When are your symptoms the best? D Morning D Afternoon D Evening D Night D After activity

Patient Signature:_____