

Physical Therapy Medical Screening Questionnaire

Date: _____

Name: _____

SSN: _____

Gender: Male Female Age: _____

Smoker: Yes No Pregnant: Yes No

Occupation _____

Describe your regular exercise routine: _____

Past Surgical History (list all, date):

Please list all current Medications:

Have you had an X-ray, MRI or other imaging study? Y N

Past Medical History Please mark each condition that you have or had:

Cancer

Heart Disease

Liver Disease

Have you had a recent illness (explain)?

High Blood Pressure

Osteoarthritis

Ulcers

Osteoporosis

Lung Disease

Rheumatoid Arthritis

Allergies/Asthma

Kidney Disease

Stroke

Do you take blood thinners? Yes No

Diabetes

Angina/Chest Pain

Fibromyalgia

Are you allergic to latex? Yes No

During the past month, have you often been bothered by feeling down, depressed or hopeless? Yes No

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes No

Currently I am Experiencing Please mark each condition that applies:

Depression

Shortness of Breath

Nausea/Vomiting

Increased Pain at Night

Change in Bowel
or Bladder Function

Fevers/Chills/Sweats

Poor Balance (Falls)

Unexplained Weight
Loss/Gain

Numbness or Tingling

Changes in Appetite

Difficulty Swallowing

Dizziness

Headaches

Current Symptoms

Where are you currently having symptoms? _____

Approximately what date did your present pain begin? _____

How (gradually, suddenly, injury)? _____

My symptoms are currently: Getting better / About the same / Getting worse

Have you received any treatment for this problem before? Yes No

If yes, how was the problem treated? _____

How long did it take for you to feel better? _____

How are you able to sleep at night? Fine / Moderate difficulty / Only with medication

What is your personal goal for therapy? _____

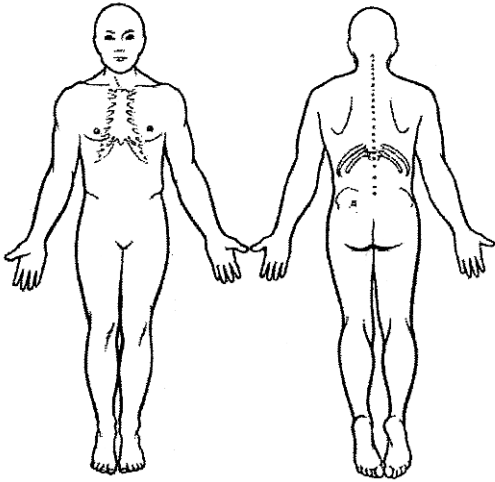
Do you have any barriers to learning? If yes, please list. _____

CONSENT I understand that my diagnosis and treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered. _____

Signature

FLIP OVER

Body Chart *Please mark the areas on the chart where you feel pain.*



For the therapist
 + / - Cough/Sneeze
 + / - Saddle Anesth
 + / - Bwl/Blddr Change
 + / - Numb/Ting

On the scales below, please circle the number which best represents the severity of your pain.

Average for the last 48 hours:

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

Best for the last 48 hours:

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

Worst for the last 48 hours:

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

Please circle the number below which best represents your overall level of function.

Cannot do anything 1 2 3 4 5 6 7 8 9 10 Able to do everything

What makes your symptoms better? _____

Please circle the activities which make your pain worse.

Sitting Standing Stress Walking Lying Down

Any other activities that make youR pain worse?

Please list the best and worst time of the day for your symptoms:

Best: _____ Worst: _____

Aggravating Factors

Identify and list up to three important activites that you are unable to do or are having difficulty with as a result of your problem.

1. _____
2. _____
3. _____