Physical Therapy Medical Screening Form

Date:_____

Patient Information		
Name:	Date of Birth/Age:	
Current Problem:	Date of Injury (if applicable):	
Recent Surgery:	Date of Surgery:	
Currently: ☐working ☐not working ☐retired ☐other	Occupation (or previous occupation):	
Sport(s):	School:	Grade:
With whom do you live?	Pets:	
Hobbies/Activities:		
Beliefs that might affect your care:		
Housing: ☐house ☐apartment ☐condo ☐mobile home ☐other:_____ Do you have stairs? ☐yes ☐no A railing? ☐yes ☐no Steep lot? ☐yes ☐no		

History

Latex sensitive ☐yes ☐no
Smoker ☐yes ☐no
Pacemaker ☐yes ☐no
Pregnant ☐yes ☐no
Osteoporosis ☐yes ☐no
Pins or Metal ☐yes ☐no

Please check all the conditions that apply to your immediate **family** (parents, siblings).
☐cancer ☐heart problems ☐diabetes
☐stroke ☐inflammatory arthritis
☐depression ☐kidney disease ☐alcoholism

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

☐cancer ☐rheumatoid arthritis
☐diabetes ☐other arthritis
☐high blood pressure ☐depression
☐heart problems ☐tuberculosis
☐stroke ☐bone/joint infection
☐HIV ☐hepatitis
☐asthma ☐COPD
☐chemical dependency ☐seizures
☐blood clots ☐other:_____

Please rate your general health: ☐excellent ☐good ☐fair ☐poor
Any major life changes in the past year? ☐yes ☐no Explain:_____
Past surgeries/injuries/hospitalizations:_____
Any allergies? ☐yes ☐no Please Explain:_____

Recently, I have experienced the following (check all that apply):

☐unexplained weight loss ☐difficulty swallowing ☐dizziness
☐poor balance/falls ☐headaches ☐depression
☐fever/chills/sweats ☐nausea/vomiting ☐shortness of breath
☐numbness/tingling ☐change in appetite ☐change in bowel/bladder
☐other:_____ ☐change in vision ☐none

Current Medications/Supplements (or provide a list we may copy)

Medication Name	Used For	Dosage	Times per day

Health Care Management Team

Please list health care practitioners whose care you are currently under (name and title):

_____

_____

Date of last physical exam by a medical doctor (MD):

Current Condition

What are your current symptoms?_____

When did these problems start?_____

How did this happen?_____

Have you ever had this problem before? □yes □no

Please list any previous treatment for your current condition:_____

_____

Have you had any imaging studies done for this problem? (x-rays, MRI, etc.) □yes □no

If yes, explain:_____

Are you currently: □getting better □getting worse □staying about the same

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

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

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

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

Easing Factors: Identify up to 3 positions or activities that make you feel better:

_____ _____ _____

Aggravating Factors: Identify up to 3 positions or activities that make you feel worse:

_____ _____ _____

Functional Activities: Identify activities important to you that you are experiencing difficulty performing due to your current condition: _____

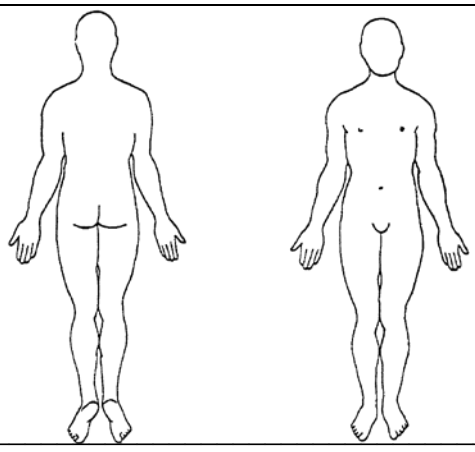
_____

What are your physical therapy and/or fitness goals?

Body Chart

Please mark the areas where you feel symptoms, using the following symbols to describe your symptoms:

↓ shooting/sharp pain
O dull/ache
× numbness
^ tingling



_____

Patient Signature:_____