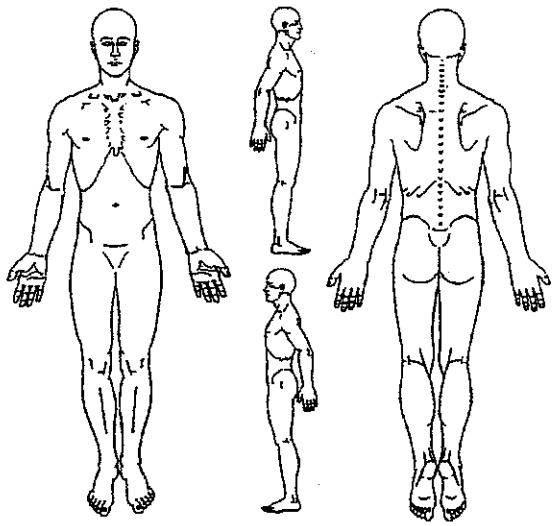
Physical Therapy Medical Screening Questionnaire



Date ___/___/___
Name _____
Date of Birth___/___/___
Gender M__ F__ Age ___

Please mark the areas where you feel symptoms on the chart to the right.

////////// Pain
+++++ Tingling
-------- Numbness
00000 Weakness

Current Symptoms:
Where are you currently having symptoms?

_____

What date (approximately) did the pain start? _____
How did the pain begin (gradually, suddenly, injury)? _____
My symptoms are currently: **Getting better About the same Getting worse**
Have you received any treatment for this problem? _____

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

Worst for the last 48 hours:
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Right now:
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Best in the last 48 hours:
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

What positions or activities make your symptoms worse?

_____

What positions or activities make your symptoms better?

_____

Have you ever had this problem before? **Yes No**
If so, how was the problem treated? _____
How long did it take you to feel better? _____

Name _____ Date of Birth___/___/___

Past Relevant Surgery (with approximate dates)

_____

_____

Occupation _____

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

Currently I am experiencing (circle all that apply): Fever/chills/sweats Poor balance Unexplained Weight Loss Numbness or tingling Changes in Appetite Difficulty Swallowing Depression Shortness of Breath Dizziness Headaches Nausea / Vomiting Changes in bladder or bowel function Increased pain at night Fatigue / Weakness

How are you able to sleep at night? **Fine Moderate Difficulty Only with Medication**

Smoker Y__ N__ Pregnant Y__ N __

Please circle each condition that you have (or have had): Cancer Diabetes Stroke Kidney Disease Liver Disease Pacemaker High Blood Pressure Heart Disease Angina/Chest Pain Ulcers Fibromyalgia Osteoporosis Osteoarthritis Rheumatoid Arthritis Sexually Transmitted Disease Allergies/Asthma Lung Disease Diseases of the Reproductive Organs

Recent Illness _____

Do you have Hepatitis C? YES NO Do you have HIV? YES NO

Do you have cardiac stents? YES NO Have you had other cardiac procedures? YES NO

Describe _____

Do you take blood thinners? YES NO Are you allergic to latex? YES NO

During the past month, have you been bothered by feeling down, depressed or hopeless? YES NO

During the past month, have you been bothered by little interest or pleasure in doing things?YES NO

Is this something with which you would like help? YES YES BUT NOT TODAY NO

Results of recent x-ray, MRI or other imaging study

_____

_____

Please list all medications and dosages

_____

_____

What is your personal goal for therapy? _____

Describe your regular exercise routine:

_____

Do you have any barriers to learning? If so list: _____

Is there anything else that you feel it would be helpful for your physical therapist to know about you?

_____

This has been reviewed by the Physical Therapist _____PT signature