



Physical Therapy Medical Screening Questionnaire

Date: _____
 Name: _____
 Social Security #: _____ - _____ - _____
 Gender: M F Age: _____
 Smoker: Y N Pregnant: Y N
 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?

Past Medical History: Please circle each condition that you have been told you have (or had).

Cancer Diabetes Kidney Disease Liver Disease Stroke
 High Blood Pressure Heart Disease Angina/Chest Pain Ulcers Fibromyalgia
 Osteoporosis Osteoarthritis Rheumatoid Arthritis Sexually Transmitted Disease
 Allergies/Asthma Lung Disease Have you had a recent illness (explain if yes)? _____
 Do you take blood thinners? YES NO Are you allergic to latex? YES NO Other: _____

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 (circle all that apply): Fever/chills/sweats Poor balance (falls)
 Unexplained weight loss Numbness or Tingling Changes in appetite Difficulty swallowing
 Depression Shortness of breath Dizziness Headaches
 Changes in bowel or bladder function Nausea /Vomiting Increased pain at night

CURRENT SYMPTOMS

Where are you currently having symptoms? _____

What date (approximately) did your present pain start? _____

How (gradually, suddenly, injury)? _____

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

Have you received any treatment for this problem? _____

Have you ever had this problem before: **YES** / **NO**

If so, 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? _____

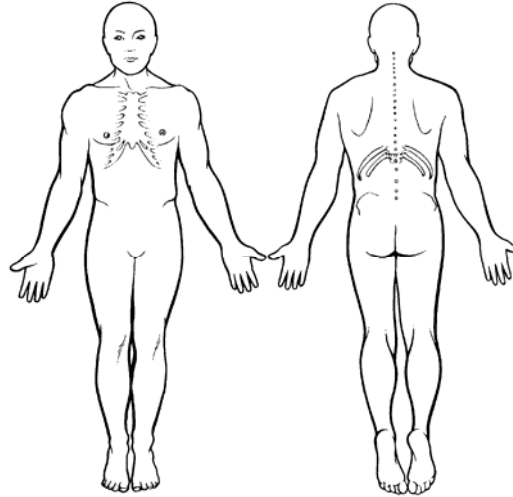
Do you have any barriers to learning, if so list? _____

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

TURN OVER

Body Chart:

Please mark the areas where you feel pain on the chart to the right



For the therapist

- + / - Cough/Sneeze
- + / - Saddle Anesth.
- + / - Bwl/Blddr Chnge
- + / - Numb/Ting.

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

Average for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Best for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Worst for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

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

Cannot do anything 0 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
 lying down standing
 walking stress

Any other activities that make your pain worse?:

Please list the best and worst time of day for your symptoms } Best -
 } Worst -

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. List them below:

- 1) _____
- 2) _____
- 3) _____

Below for the Therapist:

Rating: _____
 Rating: _____
 Rating: _____
 AVG: _____

| | | |
|-----------------------------------|---|--|
| Unable to perform activity | <p style="margin: 0;">Therapist Use</p> <p style="margin: 0;">0 1 2 3 4 5 6 7 8 9 10</p> | <p style="margin: 0;">Able to perform activity at same level as before your (injury or problem)</p> |
|-----------------------------------|---|--|