Medical Screening Form

Date: _______________

Patient Information	
Patient Name:	Date of Birth/Age:
Current Diagnosis:	Date of Injury (if applicable):
Currently: ☐ Working ☐ Not working ☐ Retired ☐ Other	Occupation (or previous occupation):
Do you have beliefs that may affect your care? ☐ Yes ☐ No	With whom do you live?

Type of housing: ☐ House ☐ Apartment ☐ Condo ☐ Other : ___________________________________

Do you have stairs? ☐ No ☐ Yes If "yes", do you have a railing? ☐ Yes ☐ No

History

Regular Exercise? ☐ Yes ☐ No Type of exercise: ________________________ How often? __________

Tobacco Use	
☐ Never ☐ I quit ☐ I still smoke ☐ Smokeless tobacco	Please rate your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Have you had any major life changes in the past year? ☐ Yes ☐ No Please explain: ____ Do you have allergies? ☐ Yes ☐ No Explain: ______________________________

Are you, or is there a chance you could be pregnant? ☐ Yes ☐ No

Do you have a pacemaker or implant of any kind? ☐ Yes ☐ No

If "yes", please explain: ____

Please list any communication barriers (i.e. hearing, vision speech) or other information you feel is important.

____

Please list any other health problems or surgeries: ____

Currently, I am experiencing the following:

☐ Unexplained weight loss
☐ Changes in Bowel or Bladder Function
☐ Fever/ Chills/ Sweats
☐ Changes in Appetite
☐ Other: ____
☐ Difficulty swallowing
☐ Headaches
☐ Nausea / Vomiting
☐ Numbness or Tingling
☐ Dizziness
☐ Depression
☐ Shortness of Breath
☐ Poor Balance / Falls
☐ None

Current Medications—Please complete or provide a list we may copy

Medication Name	**Dosage**	**# Times Daily**

B V P T

Current Condition

Where are you currently having symptoms? ____

____

When did these symptoms start? ____

How did this injury occur? (i.e. Gradually, suddenly, traumatic incident, etc.) ___________________________

____

Have you ever had this problem before? ☐ Yes ☐ No

Please list any previous treatment for this injury: ____

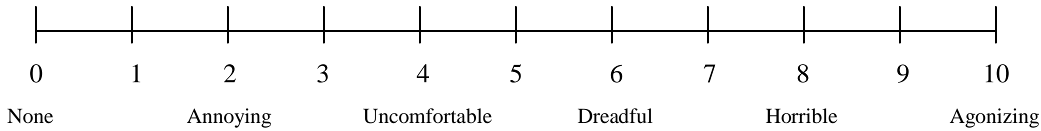
____

Have you had any imaging studies done for this problem? (i.e. x-ray, MRI, etc.) ☐ Yes ☐ No

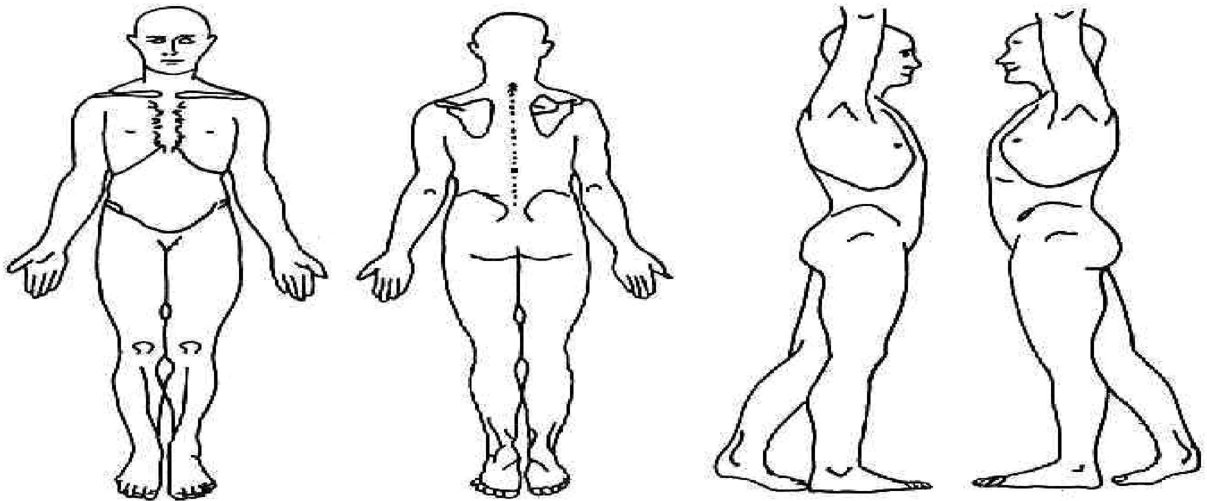
If "yes" please explain: ____

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

Please rate your pain using the following scale:



Currently: ___________ Best: ____________ Worst: ___________



Please use the following symbols to mark your areas of pain:	My pain is:
^^^^^^ Tingling !!!!!!! Pinching Other: ***** Pins and Needles ><>< Burning //////// Numbness +++++ Ache	☐ Constant ☐ Occasional ☐ Periodic ☐ Worse in the morning ☐ Worse in the evening ☐ Time of day doesn't matter

What are your physical therapy and/or fitness goals? ____

____

____