Medical Screening Questionnaire

Date: _____
Name: _____
Insurance: _____
Doctor:_____

Gender: M F Age:
Smoker: Y N Pregnant: Y N
Occupation:_____
Describe your regular exercise routine:_____
_____
_____

Marital Status:_____

Past Surgical History (list all & date)
_____
_____
_____

Please List All Current Medications
_____
_____

Have you had an x-ray, MRI, or other imaging study?_____
_____

Height:_____ **Weight:**_____

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			

Do you have or have you had a recent illness or infection (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)	Anxiety		
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			

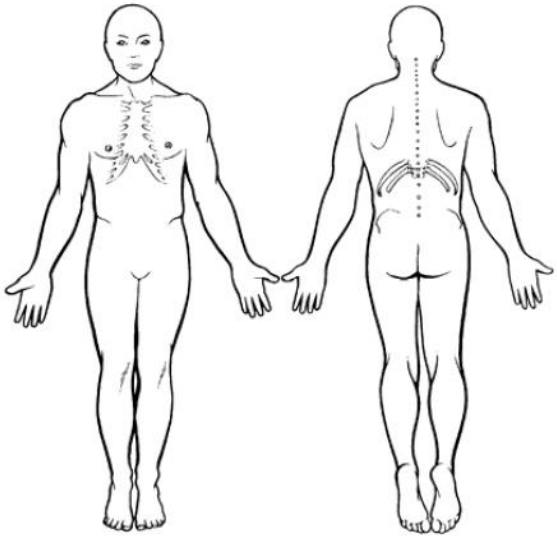
CURRENT SYMPTOMS

Where are you currently having symptoms? _____
What date (approximately) did your present pain start_____
How did it start? (gradually, suddenly, injury)?_____
My symptoms are currently: **Getting better / About the same / Getting worse / Fluctuating**
Have you received any treatment for this problem? **YES / NO** 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/Bldder 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:

lying down
walking
sitting
standing
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:_____

Therapist Use

Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 Able to perform activity at same level as before your (injury or problem)