

Medical Screening Form

Name: _____ DOB: _____ Age: _____

Height: _____ Weight: _____ Primary Care Physician: _____

Your overall health right now is (circle): Excellent Very Good Good Fair Poor

Medical History

Please check if you recently had any of the following: Clarify responses below as needed

- | | | |
|---|--|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Not feeling well | <input type="checkbox"/> Change in mental function |
| <input type="checkbox"/> Vomiting/ nausea | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Numbness/ tingling | <input type="checkbox"/> Dizziness/ light headedness | <input type="checkbox"/> Any Infection |
| <input type="checkbox"/> Fever/chills/ sweats | <input type="checkbox"/> Loss of Balance/ Falls | <input type="checkbox"/> Cold / Cough / Flu |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Weight Change | <input type="checkbox"/> Change in bowel /bladder function |

Comments: _____

Have you ever been diagnosed with any of the following conditions?

- | | | |
|---|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Angina or Chest Pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Pneumonia/ Bronchitis | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease/ stones | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Stomach aches/ nausea | <input type="checkbox"/> Liver Disease / Hepatitis | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Balance/ Falls | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Gynecological Disorders | <input type="checkbox"/> Change in ability to urinate |
| <input type="checkbox"/> AIDS/ HIV | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Weight Change |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Cold / Flu / Cough | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Fever/chills/ sweats | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Numbness/ tingling | <input type="checkbox"/> Depression/ Anxiety |
| <input type="checkbox"/> Metal Implant please specify: | | |
| <input type="checkbox"/> Organ Transplant please specify: | | |

Life Style

Do you exercise? YES NO

What types of exercise?

How often? _____ x/week For how many minutes? _____

Do you smoke tobacco? YES NO If yes, average cigarettes/day? _____

For women: Are you currently pregnant or think you might be pregnant? YES NO

During the past month have you been feeling down, depressed or hopeless? _____

During the past month have you been feeling little interest or pleasure in doing things? _____

Is this something with which you would like help? YES YES, but not today NO

Medical Screening Form

Medications

Name: _____

Are you currently taking any blood thinners? YES NO

Any steroids medication (Cortisone, prednisone, dexamethasone, ect.) or inhalers? YES NO

Please list your current medications with dosages: (INCLUDE: pills, injections, inhalers, and/or skin patches):

Operations

Please list any operations that you have had and the approximate date:

Date Operation:

Diagnostic Tests

	Date	Significant Results:
X-Ray		
EMG		
MRI/CT		
Bone Density		
Blood Tests		

Current Symptoms

Where are your current symptoms?

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What activities or positions make your symptoms worse?

What do you do to relieve your symptoms?

What are your personal goals for physical therapy?

Patient Signature _____

PT Initials _____ Date _____