PACRAN
PHYSICAL THERAPY . RENO . NV

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

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

Comments:_____

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

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

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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:

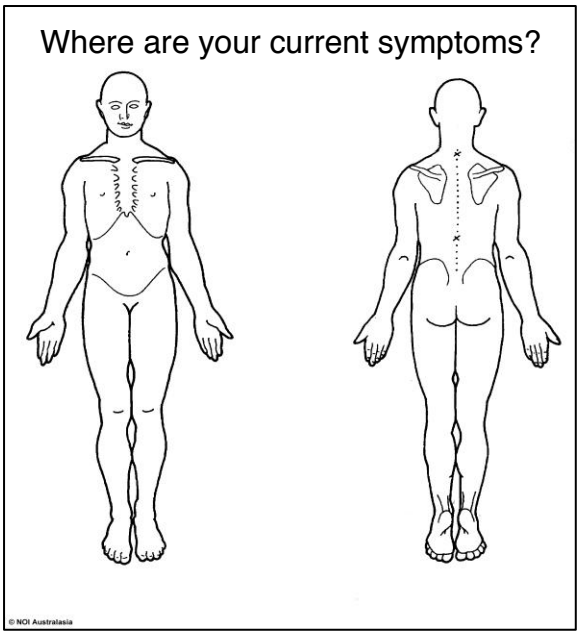
Date	Operation:
_____	_____
_____	_____
_____	_____
_____	_____

Diagnostic Tests

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

Current Symptoms

Where are your current symptoms?



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 _____