

COMPLETE PERFORMANCE Physical Therapy Medical Screening Questionnaire Questionnaire

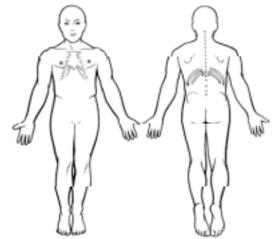
			Past Surgical Hi	story (list all &d:	<u>ate):</u>	
Date:						
Name:		_				
Social Security #: Gender: M F Age:		-	Please List All C	urrent Medica	tions:	
Smoker: Y N Pregna	ant: Y N					
Occupation:			Have you had a	an x-ray, MRI,	, or	
Describe your regular exercise			other imaging study?			
routine:			•			
Past Medical Histo	ry: Please circle each	con	dition that you h	ave been told w	you have (or had).	
Cancer High Blood Pressure Osteoporosis Disease	Diabetes e Heart Disease Osteoarthritis Allergies/Asthma Do you take	Kid Ang Rhe Lun	ney Disease gina/Chest Pain eumatoid ng Disease	Liver Disease Ulcers Arthritis Have you had	Stroke Fibromyalgia Sexually Transmitted a recent illness (expla	d ain if
	th, have you often beatth, have you often beat		•	-	<u>-</u>	
Currently I am experiencing (circle all that a Unexplained weight loss Numbness or Tingl Depression Shortness of breath Changes in bowel or bladder function			ling Changes in appetite Difficu n Dizziness Heada		Poor balance (falls) Difficulty swallowing Headaches Increased pain at night	
What date (approximate) How (gradually, sud	TOMS ently having symptom nately) did your prese denly, injury)? urrently: Getting bett	ent pa	in start?			
Have you received any treatment for this problem?						
Have you ever had this problem before: YES / NO						
If so, how was the problem treated?						
	for you to feel better					
	o sleep at night? Fine rapy?					
Do you have any bar	rriers to learning, if so	list?				
"	stand that my diagnos to question and/or ref		-		0 11	nt and (Sign)

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:	W (D. V. J.)							
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								
XXII 4 1 4 9								
What makes your symptoms better?	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 Best -								
of day for your symptoms 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)								
J1								

