# Physical Therapy Medical Screening Questionnaire

**Date:**____________________

**Name:**________________________________

**Social Security #:** __ __ __ **-** __ __ **-** __ __ __ __

Gender: M F Age:

Smoker: Y N Pregnant: Y N

Occupation:

Describe your regular exercise routine:

**Past Surgical History (list all &date):**

________________________________
________________________________
________________________________

**Please List All Current Medications:**

________________________________
________________________________

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

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**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 Have you had a recent illness (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

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**Currently I am experiencing (circle all that apply):** Fever/chills/sweats Poor balance (falls)
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

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**CURRENT SYMPTOMS**

Where are you currently having symptoms? ______________________________________

What date (approximately) did your present pain start?______________________________

How (gradually, suddenly, injury)?___________________________________________

My symptoms are currently: **Getting better / About the same / Getting worse**

Have you received any treatment for this problem?_________________________________

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)

## 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:

**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:** sitting

lying down standing

walking 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)________________________________________________

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