

Physical Therapy Medical Screening Questionnaire

Date: _____

Name: _____

Gender: M F

Age: _____

Smoker: Y N

Pregnant: Y N

Occupation: _____

Describe your regular exercise routine: _____

Medication	Dose	How Taken
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		
10. _____		

Past Surgical History: (Please List and Date): _____

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: _____		

Currently I am experiencing (circle all that apply):

Unexplained weight loss	Numbness or tingling	Fever/chills/sweats	Poor balance (falls)
Depression	Shortness of Breath	Changes in appetite	Difficulty swallowing
Changes in bowel or bladder function		Dizziness	Headaches
		Nausea/Vomiting	Increased pain at night

CURRENT SYMPTOMS:

Where are you currently having symptoms? _____

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

How (gradually, suddenly, injury)? _____

Have you had any treatment for this problem? _____

If so, how was the problem treated? _____

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

What is your personal goal for therapy? _____

TURN OVER

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:

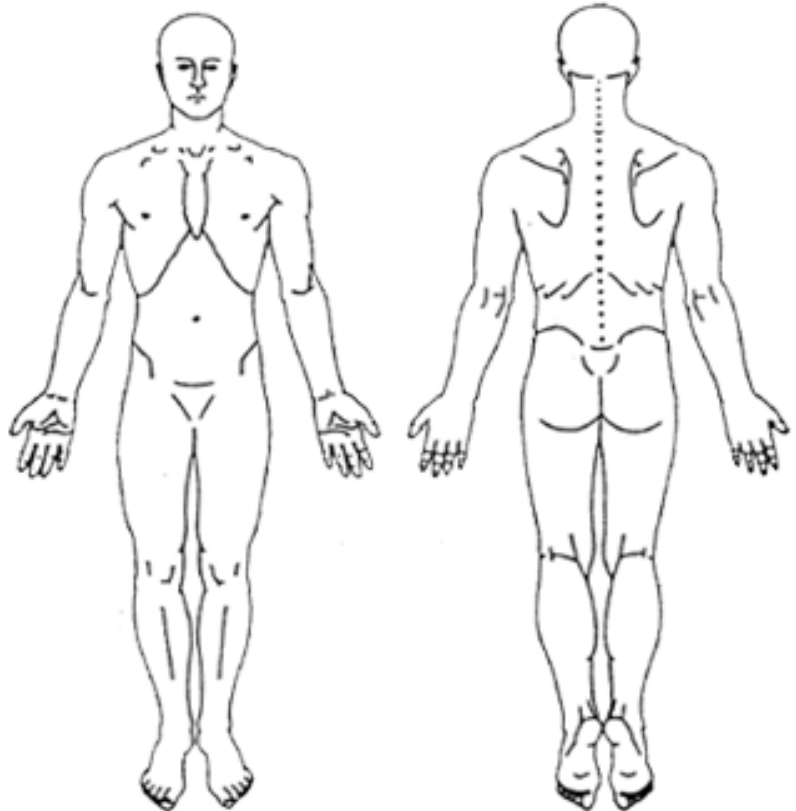
No pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Worst for the last 48 hours:

No pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Body Chart:

Indicate where your pain is located and what type of pain you feel at the present time. Fill in the areas on the body diagram with the appropriate symbols below to describe your pain. Do not indicate areas of pain that are not related to your present injury or condition.



KEY:

- /// STABING
- XXX BURNING
- OOO PINS AND NEEDLES
- === NUMBNESS

For the therapist

- +/- cough/sneeze
- +/-saddle anesth
- +/- bwl/bladder chang
- +/- numb/ting

What makes your symptoms better?

Please circle the activities which make your pain worse:

- lying down
- standing
- walking
- stress
- sitting
- bending
- lifting
- first thing in the AM
- end of day

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 _____