PRO PHYSICAL THERAPY MEDICAL SCREENING QUESTIONAIRE

Date: ___/____/_____

Name: _____

GENDER: F M AGE: _____ Pregnant: Y N
HEIGHT: _____WEIGHT: _____
SMOKER: 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?

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)? _____**

Any Fractures? _____

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

Currently I am experiencing (circle all that apply):

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

On the scales below, please circle the number which best represents the severity of your pain.

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 activities which make your pain worse:

Lying down **standing** **walking** **stress** **sitting**

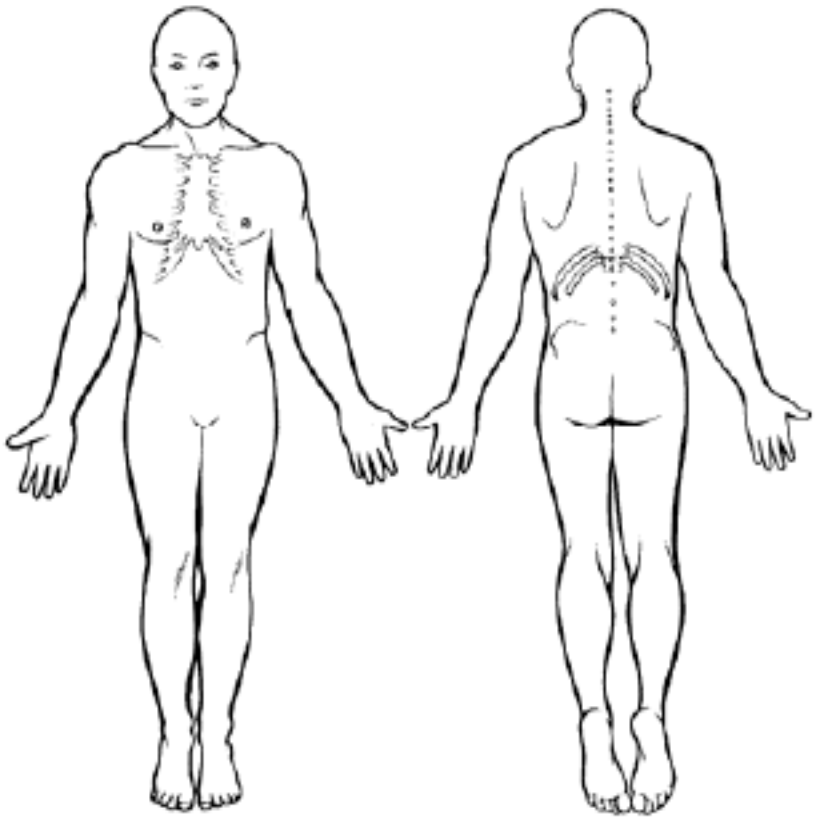
Any other activities that make your pain worse?

Please list the best and worst time of day for your symptoms: Best-

Worst-

Over

Body Chart:
Please Mark the areas where you feel pain on the chart below.



Please use the symbols below to describe your pain:
Deep ache=**Z** Pins/Needles=**0**
Stabbing=/ Burning=**X**

For the Therapist:
+ / - Cough/Sneeze
+ / - Saddle Anesth.
+ / - Bwl/Bladdr Chnge
+ / - Numb/Ting.

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? _____
_____

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: _____

Therapist Use Only

Unable perform activity	0 1 2 3 4 5 6 7 8 9 10	**Able to perform activity at same level as before your (injury or problem)**

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
Personal goal for therapy? _____
Any barriers to learning, if so list? _____

Medical History was reviewed on (DATE): ____/____/_____

Signature of Therapist:_____