Physical Therapy Medical Screening Questionnaire Client Information

Name: _____ Date: _____ Age: _____

Purpose of your visit today: _____

Please complete this form to help provide important information to your therapist to ensure you receive a thorough and complete evaluation. Your therapist will review your answers with you. Please ask, if you have any questions. Thank you!

Date of your last physical examination: _____ Height: _____ Weight: _____

Are you sensitive to latex?	☐ Yes	☐ No	*FOR WOMEN:* Are you currently pregnant or do you think you might be pregnant?	☐ Yes	☐ No		
Do you smoke?	☐ Yes	☐ No					
Do you drink alcohol?	☐ Yes	☐ No	Do you have regular menstruations?	☐ Yes	☐ No		
Do you have a pacemaker?	☐ Yes	☐ No	Have you gone through menopause?	☐ Yes	☐ No		

ALLERGIES: Please list any allergies you have, including medications, and what your response is to the allergen:

_____

Have you RECENTLY noted any of the following (check all that apply)?

☐ fatigue	☐ numbness or tingling	☐ difficulty breathing
☐ fever/chills/sweats	☐ muscle weakness	☐ fainting
☐ nausea/vomiting	☐ dizziness/lightheadedness	☐ chronic coughing
☐ weight loss/gain	☐ confusion/ change in mental status	☐ night pain
☐ vision changes (blurred, double, etc.)	☐ difficulty swallowing	☐ heartburn/indigestion
☐ falling down	☐ problems urinating / bladder leakage	☐ headaches
☐ poor balance while walking	☐ constipation / diarrhea	☐ tremors/ seizures
☐ stress at home or work	☐ arm or leg swelling	☐ tripping frequently
☐ eye redness	☐ skin rash	☐ weight changes

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

☐ cancer Type? _____	☐ depression / anxiety	☐ thyroid problems
☐ heart problems	☐ lung problems	☐ diabetes
☐ chest pain/ angina	☐ tuberculosis	☐ osteoporosis /osteopenia
☐ high blood pressure	☐ asthma	☐ multiple sclerosis
☐ circulation problems	☐ rheumatoid / inflammatory arthritis	☐ epilepsy
☐ blood clots	☐ other athritic condition	☐ eye problem/ infection
☐ stroke	☐ bladder/ urinary tract infection (UTI)	☐ ulcers
☐ anemia	☐ kidney problem/ infection	☐ liver problems
☐ bone or joint infection	☐ sexually transmitted disease/ HIV	☐ hepatitis
☐ chemical dependency (i.e., alcoholism)	☐ pelvic inflammatory disease	☐ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

☐ cancer Type? _____	☐ diabetes	☐ tuberculosis (TB)
☐ heart problems / heart disease	☐ stroke	☐ thyroid problems
☐ high blood pressure	☐ depression	☐ blood clots
☐ inflammatory arthritis (rheumatoid, anklyosing)	☐ chemical dependency / alcoholism	☐ kidney disease

Do you ever feel unsafe at home or has a partner or anyone in your life hurt, hit or threatened you?			☐ Yes	☐ No
During the past month have you been feeling down, depressed or hopeless?			☐ Yes	☐ No
During the past month have you been bothered by having little interest or pleasure in doing things?			☐ Yes	☐ No
If yes to any, is this something with which you would like help?	☐ Yes, but NOT today		☐ Yes	☐ No

What are your primary goals coming to physical therapy today? What would you like to accomplish with the help of therapy?

_____

_____

Print Name: _____

Physical Therapy Medical Screening Questionnaire Client Information

What is your current work status? ☐ Full time ☐ Part-time ☐ Light Duty ☐ Unemployed
☐ Retired ☐ Not working due to this issue/injury ☐ Disabled ☐ Full time homemaker/caregiver

Job title or type of work you do or did most recently: _____

Do you plan to return to this work? ☐ Yes ☐ No

Do you feel this issue/injury will keep you from returning to this or similar work? ☐ Yes ☐ No

What is your usual activity level? ☐ very active/ athletic ☐ moderately active ☐ minimally active/ sedentary

What are your favorite hobbies or activities? _____

Please rate your *Overall Functional Ability* with 0 as "unable to function at all" and 10 as "no issue or limitation".
(Please consider all aspects of your life in the rating, including self-care (dressing, bathing), work, recreation, social activities, etc.)

*Circle your **current** level of function:* 0 1 2 3 4 5 6 7 8 9 10

*Circle your level of function **before** this issue/problem:* 0 1 2 3 4 5 6 7 8 9 10

Please list any medications you are currently taking or using (INCLUDING prescribed and over-the counter, pills, injections, creams, skin patches, supplements and/or herbals) or attach a copy of a current medication list: ☐ See attached list

_____

_____

_____

Have you ever taken steroid medications for any medical conditions? ☐ Yes ☐ No

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? ☐ Yes ☐ No

Please list surgeries or other conditions for which you have been hospitalized and any other major injuries or illnesses. Include dates.

_____

_____

_____

What date (roughly) did your present problem start? _____

Issue started: ☐ gradually over time ☐ related to an injury

Treatment received so far for this problem (chiropractic, injections, physical therapy, surgery, etc):

_____

_____

Please list special tests performed for this problem (x-ray, MRI, labs, etc), including when and where completed:

_____

_____

What are your top 1-3 areas of symptoms, in order of how severe they are? (Ex. low back, shoulder, etc.)

#1 _____ #2 _____ #3 _____

My symptoms are currently: ☐ getting better ☐ getting worse ☐ staying about the same

My symptoms currently: ☐ come and go ☐ are constant ☐ are constant, but change with activity

How are you currently able to sleep at night due to your symptoms?

☐ no problem sleeping ☐ difficulty falling asleep ☐ awakened by pain ☐ sleep only with medication

When are your symptoms worst? ☐ morning ☐ afternoon ☐ evening ☐ night ☐ after activity

When are your symptoms best? ☐ morning ☐ afternoon ☐ evening ☐ night ☐ after activity

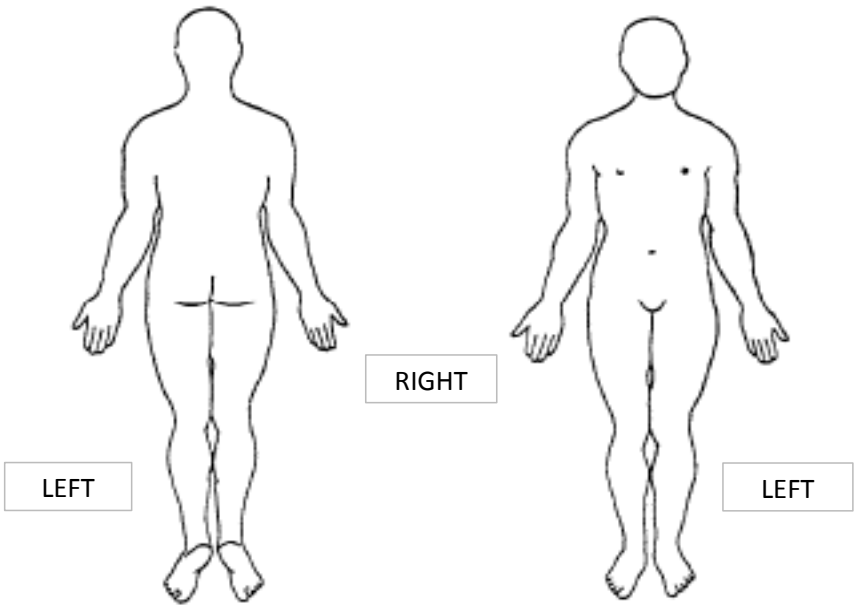
Print Name: _____

Physical Therapy Medical Screening Questionnaire Client Information

BODY CHART

Please mark the areas where you feel symptoms on the chart to the right.
Use the following symbols to describe your symptoms:

- X **Sharp pain**
- ↓ **Shooting pain**
- O **Dull/aching pain**
- ||| **Numbness**
- = **Tingling**



Using the 0 to 10 the scale, with 0 being "*no pain*" and 10 being the "*worst pain imaginable*" please describe:

*Circle your **current** level of pain while completing this survey:*	0	1	2	3	4	5	6	7	8	9	10
*Circle the **best** your pain has been during the past 24 hours:*	0	1	2	3	4	5	6	7	8	9	10
*Circle the **worst** your pain has been during the past 24 hours:*	0	1	2	3	4	5	6	7	8	9	10

Easing Factors: Identify **up to 3** important positions or activities that make your symptoms *better* :

1. _____
2. _____
3. _____

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. Rate your difficulty with the activity based on a 0 to 10 scale with 0 being "*unable to perform*" and 10 being "*able to perform activity at the same level as before injury or problem began.*" *(Patient Specific Functional Scale)*

1. _____

*Circle your **current** ability to perform the above activity you listed:*	0	1	2	3	4	5	6	7	8	9	10

2. _____

*Circle your **current** ability to perform the above activity you listed:*	0	1	2	3	4	5	6	7	8	9	10

3. _____

*Circle your **current** ability to perform the above activity you listed:*	0	1	2	3	4	5	6	7	8	9	10

How long can you do each of these activities without increasing symptoms?

Sitting ☐ mins/hrs ☐ No limitation **Standing** ☐ mins/hrs ☐ No limitation **Walking** ☐ mins/hrs ☐ mile(s) ☐ No limitation

Is there any other information that was not included on this form that you would like your therapist to know about you?

_____

Patient Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

Print Name: _____