Physical Therapy Medical Screening Questionnaire

Date ____/____/____ Name _____ **Age**?_____

Name of primary care doctor: _____

Reason for Physical therapy visit? _____

How did your symptoms start?(ex: accident or fall or injury at work) _____

When did your current symptoms start? _____

Is this the first time you have had these symptoms? YES NO

Are your symptoms: ☐getting better ☐staying the same ☐**getting worse**

When are your symptoms the worst?:

☐ First thing in the morning ☐afternoon ☐evening ☐ **at night**

What activity(s) do you dislike doing because it makes your symptoms worse? _____

What makes your symptoms feel better?

☐ Medicine ☐Sitting ☐Standing ☐Heat ☐Ice ☐Lying down ☐**Moving around**

What types of tests have been performed on you? ☐X-ray ☐MRI, ☐nerve conduction test ☐blood work ☐CT

Where were the tests done? ☐Caper Fear Valley ☐Valley Regional ☐Carolina Imaging ☐ Other

How <u>frequently</u> do your symptoms occur?: ☐Constantly- (100% of day) ☐Most of the time (75%)
☐Some of the time (50%) ☐Once in a while (25% or less)

How <u>intense</u> are your symptoms when they occur? (Circle)

No Pain Worst Imaginable pain

0 1 2 3 4 5 6 7 8 9 10

Have you had to go to the E.R. for the management of your symptoms? NO YES

Do you have instances when you don't have any discomfort from your symptoms? YES NO

CURRENT: Are you currently experiencing any of the symptoms below?

☐Fatigue
☐Fever, chills or night sweats
☐Nausea or vomiting
☐Unintended weight change
☐Muscle weakness
☐Dizziness or vertigo
☐Malaise
☐Difficulty thinking or forgetfulness

Past Medical History: Please check any of the conditions below that you currently have, or have had in the past.

☐Allergies
☐Anemia
☐Anxiety/Panic disorders
☐Asthma
☐Blood clots
☐Cancer: Type_____
☐Heart disease/heart attack
☐High blood pressure
☐Cardiac Pacemaker
☐Angina/Chest pain
☐ High Cholesterol
☐COPD
☐Difficulty breathing/shortness of breath
☐Depression
☐Diabetes
☐Gall bladder disease
☐Acid reflux disease
☐Heartburn or indigestion
☐Stomach ulcers
☐Pain that gets worse with eating
☐Changes in bowel movements
☐Hernias
☐Kidney disease
☐Metal implants
☐Spinal cord stimulator
☐Osteoporosis
☐ Psoriatic arthritis
☐Rheumatoid arthritis
☐Seizures
☐Stroke
☐Thyroid disease
☐Vision problems
☐ **Latex allergy**
☐Lung disease
☐Difficult or painful urination
☐Change in the color of urine
☐Peripheral vascular disease
☐Skin ulcers
☐Ringing in ears
☐Migraines
☐ Stress urinary incontinence

For Women:

☐ Endometriosis
☐Currently pregnant

Social History:

Occupation:_____☐Married ☐Single ☐Widow

Do you drink alcoholic beverages? YES NO Do you currently smoke? No Yes

Have you smoked in the past? No Yes. How long ago did you quit? _____

Have you fallen in the last year? NO YES If yes, did you have to go the emergency room for an injury? Y N

Physical Therapy Medical Screening Questionnaire

During the past month, have you been bothered by feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by little interest or pleasure in doing things? YES NO
Would you like help with how you are feeling? ☐ Yes- today ☐ Yes - but not today ☐ No - I don't want help

Functional Limitations: Because of my symptoms, I have difficulty:

☐Bending	☐Walking	☐Pushing	☐Driving
☐Squatting	☐Running	☐Pulling	☐Exercising
☐Kneeling	☐Reaching	☐Throwing	☐ Working
☐Crawling	☐Lifting	☐Putting on clothes	☐Other:_____
☐Climbing stairs	☐Carrying	☐Putting on shoes	

Surgical History: List any surgeries you have had: (or attach list) Date:

1. _____ _____
2. _____ _____
3. _____ _____

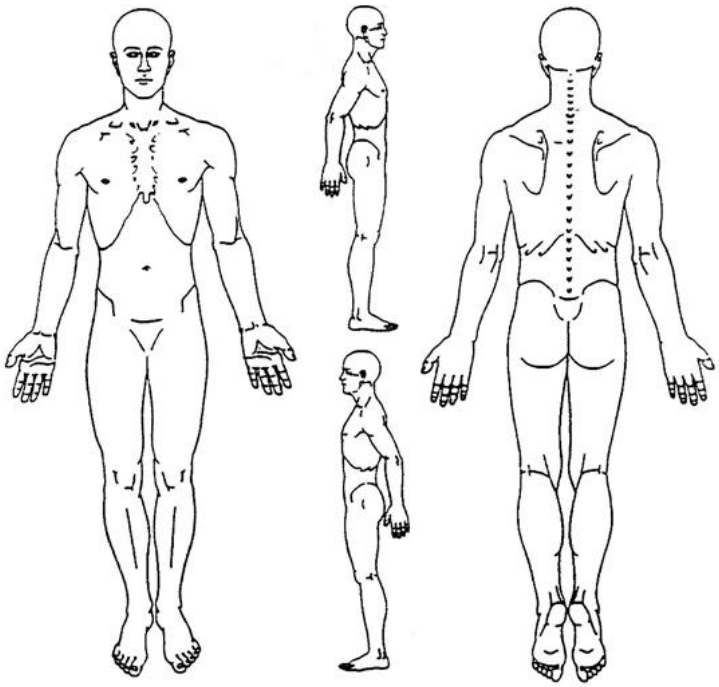
Please list all the medications that you take (or attach list)

Medication	Dose	For what medical condition?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Please indicate on the body chart where your **symptoms** are located.

➔➔➔ Burning, sharp, shooting XXX Numbness/Tingling

000 Dull/aching pain //// Throbbing



FOR THERAPIST USE – RF's

+ / - Pt >50yo?
+ / - History of cancer _____
+ / - Failure of sx's to improve

+ / - Unexplained weight loss

+ / - Night pain # Hrs sleep _____
+ / - pain w/ cough, sneeze, straining
+ / - Saddle anesthesia
+ / - Δ's bowel/bladder
+ / - Numbness tingling
Arms Legs Trunk
+ / - Difficulty swallowing

+ / - Any recent infection
+ / - Temperature

+ / - Urinary Retention?

+ / - Abdominal pulsations

+ / - Tender over SP's
+ / - Pain with percussion of spine
+ / - Prolonged corticosteroid use?

+ / - Does taking a deep breath inc sx's
+ / - Does twisting back inc sx's

Vital Signs: BP:_____

HR:_____bpm SAO2:_____%

I have reviewed contents with patient. _____ Date:_____