PHYSICAL THERAPY MEDICAL SCREENING QUESTIONAIRE

Patients Name ______________________________ Date ______________

Age ____ Height ___________ Weight ___________ Occupation ______________________

Do you smoke? Yes ___ / No ___ Do you have a pacemaker? Yes ___ / No ___

For Women: Are you currently pregnant or think you might be pregnant? Yes ___ / No ___

What recreational / leisure activities do you enjoy? ______________________________

____

____

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

____

____

Please list all current medications and dosage, including over the counter medications, vitamins, supplements:

____

____

Have you taken steroid medications for any medical conditions? Yes ___ / No ___

Have you ever taken blood thinners for any medical conditions? Yes ___ / No ___

Past Medical History (check all that apply):

___ Cancer
___ Heart Disease
___ Rheumatoid Arthritis
___ Blood Clots
___ High Blood Pressure
___ Osteoarthritis
___ Liver Disease
___ Ulcers
___ Osteoporosis
___ Lung Disease
___ Bladder Infection
___ Thyroid Problem
___ Allergies / Asthma
___ Kidney Problem
___ Stroke
___ Tubercolosis
___ Bone / Joint Infection
___ Kidney Disease
___ Fibromyalgia
___ Depression
___ Diabetes
___ Angina / Chest Pain
___ Sexually Transmitted Disease / HIV
___ Lyme Disease
___ Other: ______________________________

Has anyone in your immediate family (parents, brothers, sisters) ever been diagnosed with any of the above?

Please list: ______________________________

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

___ Fatigue
___ Weight Loss / Gain
___ Shortness of Breath
___ Fever / Chills / Sweats
___ Headaches
___ Difficulty Walking / Loss of Balance
___ Nausea / Vomitting
___ Difficulty Swallowing
___ Falls
___ Numbness / Tingling
___ Constipation / Diarrhea
___ Dizziness / Lightheadedness
___ Muscle Weakness
___ Heartburn / Indigestion
___ Changes in Bowel / Bladder Function
___ Depression

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 ___

Is this something with which you would like help? Yes ___ / Yes, but not today ___ / No ___

Current symptoms

When did your symptoms first begin? ______________________________

How did your symptoms begin (gradually, suddenly, injury)? ______________________________

My symptoms are currently: ____Getting better ____Getting worse ____Staying the same

DeWitt PHYSICAL THERAPY

Have you received any treatment for this problem? ______________________________

Have you had this problem before? Yes ___ / No ___ How long did it take for you to feel better? ____________

Have you had an X-Ray, MRI, or special testing for this problem? ______________________________

Do your current symptoms interfere with your sleep? ______________________________

Does coughing, sneezing or taking a deep breath aggravate your symptoms? Yes ___ / No ___

Does bending, sitting, lifting or twisting your back aggravate your symptoms? Yes ___ / No ___

Has there been any change in bowel habit since onset of your symptoms? Yes ___ / No ___

Does eating certain foods aggravate your symptoms? Yes ___ / No ___

Has there been any weight change since onset of your symptoms? Yes ___ / No ___

Please mark the areas where you feel symptoms on the body chart using the symptoms key below.

Symptoms Key:

↓ = shooting/sharp pain

X = dull/aching pain

≈ = numbness

V = tingling

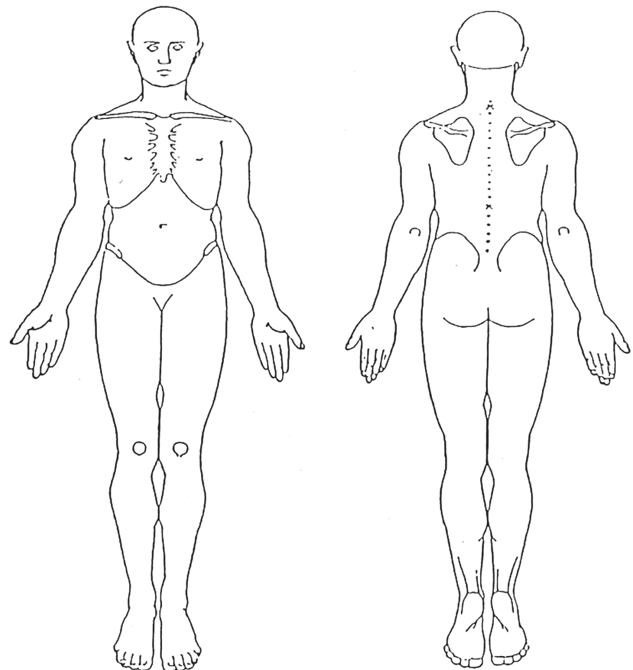
THERAPIST USE ONLY

+/– cough/sneeze

+/– saddle anesthesia

+/– bowel/bladder changes

+/– numb/ting



My symptoms currently: ___ Come and go

___ Are constant

___ Are constant, but change with activity

On the scale below, please circle the number which best describes your pain:

Average pain in the last 48 hours:	NO Pain	0	1	2	3	4	5	6	7	8	9	10	WORST Pain
Best for the last 48 hours:	NO Pain	0	1	2	3	4	5	6	7	8	9	10	WORST Pain
Worst for the last 48 hours:	NO Pain	0	1	2	3	4	5	6	7	8	9	10	WORST Pain

Is there anything you can do to reduce your symptoms? ______________________________

Is there anything that makes your symptoms worse? ______________________________

Do any of these activities make your pain worse? ___ Lying down ___ Standing ___ Walking ___ Sitting ___ Squatting

What time of day do you feel your best? ___ AM ___ Afternoon ___ PM ___ After Exercise

What time of day do you feel your worst? ___ AM ___ Afternoon ___ PM ___ After Exercise

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) ______________________________

THERAPIST

Rating ______

Rating ______

Rating ______

Average ______

UNABLE to perform activity **THERAPIST USE ONLY** ABLE to perform activity withouth difficulty

0 1 2 3 4 5 6 7 8 9 10