Date _____ MR#_____

# Physical Therapy Medical Screening Questionnaire

**Name:** _____ **Gender:** ❑ **M** ❑ **F** **Age:** _____ **Height:** _____ **Weight:** _____

**Hand Dominance:** ❑ **R** ❑ **L** **Occupation:** _____ **Place of Employment:** _____

## Past Medical History

**Relevant past surgical or hospitalization history:**

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|---|---|
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**Please list all current medications:**

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|---|---|
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**Please list Allergies:** _____

**Have you recently experienced any of the following (check all that apply)?**

Yes❑ fatigue
Yes❑ fever/chills/sweats
Yes❑ nausea/vomiting
Yes❑ weight loss/gain
Yes❑ difficulty maintaining balance (falls)
Yes❑ muscle weakness
Yes❑ numbness or tingling
Yes❑ dizziness/lightheadedness
Yes❑ changes in appetite
Yes❑ heartburn/indigestion
Yes❑ difficulty swallowing
Yes❑ change in bowel or bladder function
Yes❑ constipation/diarrhea
Yes❑ increased pain at night
Yes❑ shortness of breath
Yes❑ fainting
Yes❑ cough
Yes❑ headaches

**Have you or a family member EVER been diagnosed with any of the following conditions (check all that apply)?**

| You ↓ | Family ↓ | | You ↓ | Family ↓ | | You ↓ | Family ↓ | |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | cancer | ❑ | ❑ | depression/anxiety | ❑ | ❑ | thyroid problems |
| ❑ | ❑ | heart problems | ❑ | ❑ | lung problems | ❑ | ❑ | diabetes |
| ❑ | ❑ | chest pain/angina | ❑ | ❑ | asthma | ❑ | ❑ | osteoporosis |
| ❑ | ❑ | high blood pressure | ❑ | ❑ | osteoarthritis | ❑ | ❑ | multiple sclerosis |
| ❑ | ❑ | circulation problems | ❑ | ❑ | rheumatoid arthritis | ❑ | ❑ | fibromyalgia |
| ❑ | ❑ | blood clots | ❑ | ❑ | other arthritic condition | ❑ | ❑ | eye problem/infection |
| ❑ | ❑ | stroke | ❑ | ❑ | bladder/urinary tract infection | ❑ | ❑ | epilepsy |
| ❑ | ❑ | anemia | ❑ | ❑ | kidney problem/infection | ❑ | ❑ | liver problems/hepatitis |
| ❑ | ❑ | bone or joint infection | ❑ | ❑ | sexually transmitted disease/HIV | ❑ | ❑ | ulcers |
| ❑ | ❑ | substance abuse | ❑ | ❑ | pelvic inflammatory disease | ❑ | ❑ | other _____ |

**Have you had any falls in the last 6 months?** ❑ **Y** ❑ **N** **If so, how many times have you fallen?** _____
**Have you received any imaging?** ❑ **X-ray,** ❑ **MRI,** ❑ **Other:** _____
**Please describe your current issue and when it began. Date:** _____

_____

_____

_____

Adventist Health Howard Memorial

**Physical Therapy Summary**
Willits, CA

Patient Identification

* 3 3 5 *
Patient Questionnaire

Date _____ MR#_____

**Please circle the number which best represents the severity of your pain.**

**At WORST the last 72 hours:**

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

**At BEST the last 72 hours:**

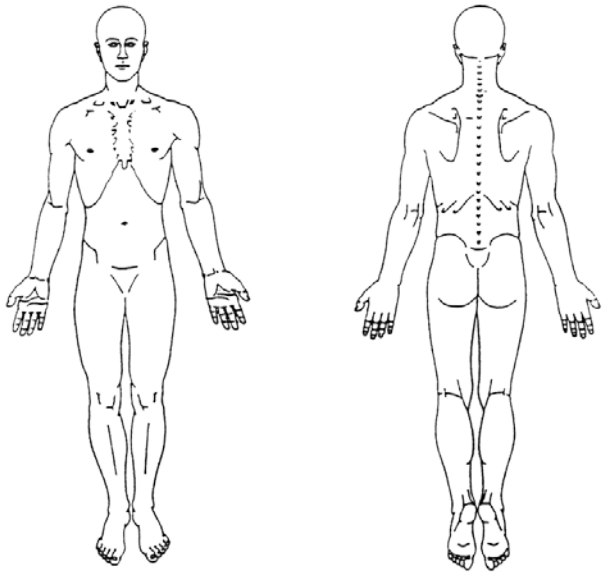
**No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain**

**AVERAGE over the last 72 hours:**

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

**Symptoms increase at night?** ❑ Y ❑ N

**Body Chart:**
**Please mark the areas where you feel pain on the chart to the right**



**What makes your symptoms worse?**

| |
|---|
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| |
| |

**What makes your symptoms better?**

| |
|---|
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| |
| |

**Have you received any treatment for this issue before? _____**

**Do you currently smoke? ❑ Y ❑ N If so how many times per day? _____**

**If you have quit smoking, how many years did you smoke for? _____**

**Do you consume alcohol? ❑ Y ❑ N If so how many times per day? _____**

**Do you use recreational drugs? ❑ Y ❑ N**

**Do you think you may be pregnant? ❑ Y ❑ N**

**Do you feel safe in your current living situation? ❑ Y ❑ N**

**Please list any functional activities you are currently having difficulty with or are unable to perform:**

1. _____
2. _____
3. _____

**What are your specific goals with physical therapy? _____**

**What methods of learning do you prefer? ❑ Written Information ❑ Verbal Instruction ❑ Demonstration**

**Patient Signature: _____**

**Parent or Guardian: _____**

Patient Identification