

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:

Please list all current medications:

Please list Allergies: _____

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

- | | | |
|---|--|--|
| Yes <input type="checkbox"/> fatigue | Yes <input type="checkbox"/> numbness or tingling | Yes <input type="checkbox"/> constipation/diarrhea |
| Yes <input type="checkbox"/> fever/chills/sweats | Yes <input type="checkbox"/> dizziness/lightheadedness | Yes <input type="checkbox"/> increased pain at night |
| Yes <input type="checkbox"/> nausea/vomiting | Yes <input type="checkbox"/> changes in appetite | Yes <input type="checkbox"/> shortness of breath |
| Yes <input type="checkbox"/> weight loss/gain | Yes <input type="checkbox"/> heartburn/indigestion | Yes <input type="checkbox"/> fainting |
| Yes <input type="checkbox"/> difficulty maintaining balance (falls) | Yes <input type="checkbox"/> difficulty swallowing | Yes <input type="checkbox"/> cough |
| Yes <input type="checkbox"/> muscle weakness | Yes <input type="checkbox"/> change in bowel or bladder function | Yes <input type="checkbox"/> 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 |
|--------------------------|--------------------------|----------------------------------|----------------------------------|--------------------------|--------------------------|
| ↓ | ↓ | ↓ | ↓ | ↓ | ↓ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| cancer | cancer | depression/anxiety | depression/anxiety | thyroid problems | thyroid problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| heart problems | heart problems | lung problems | lung problems | diabetes | diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| chest pain/angina | chest pain/angina | asthma | asthma | osteoporosis | osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| high blood pressure | high blood pressure | osteoarthritis | osteoarthritis | multiple sclerosis | multiple sclerosis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| circulation problems | circulation problems | rheumatoid arthritis | rheumatoid arthritis | fibromyalgia | fibromyalgia |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| blood clots | blood clots | other arthritic condition | other arthritic condition | eye problem/infection | eye problem/infection |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| stroke | stroke | bladder/urinary tract infection | bladder/urinary tract infection | epilepsy | epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| anemia | anemia | kidney problem/infection | kidney problem/infection | liver problems/hepatitis | liver problems/hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| bone or joint infection | bone or joint infection | sexually transmitted disease/HIV | sexually transmitted disease/HIV | ulcers | ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| substance abuse | substance abuse | pelvic inflammatory disease | pelvic inflammatory disease | other _____ | other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |

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: _____



Ukiah, CA

PHYSICAL THERAPY SUMMARY

Patient Identification



* 1 8 1 *

History and Physical Examination

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:

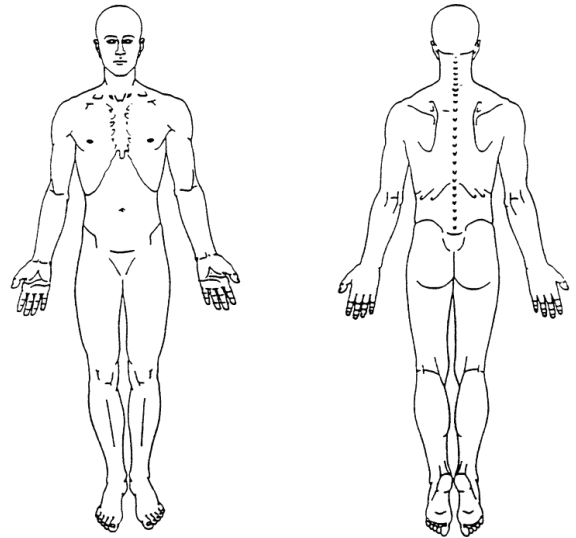
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain _____

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?

What makes your symptoms better?

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: _____



Ukiah, CA

PHYSICAL THERAPY SUMMARY

Patient Identification



* 1 8 1 *

History and Physical Examination

UK 1902 9/20/22