

# Physical Therapy Medical Screening Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Occupation: \_\_\_\_\_

Are you on a work restriction from your doctor?  Yes  No Are you latex sensitive?  Yes  No

Do you have a pacemaker/defibrillator?  Yes  No Do you smoke or recently quit?  Yes  No

FOR WOMEN: Are you currently pregnant or think you might be pregnant?  Yes  No

ALLERGIES: List any medication(s) you are allergic to: \_\_\_\_\_

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> fatigue                            | <input type="checkbox"/> numbness or tingling in groin/anal region     | <input type="checkbox"/> constipation/diarrhea |
| <input type="checkbox"/> fever/chills/sweats                | <input type="checkbox"/> change in bowel/bladder function or retention | <input type="checkbox"/> non-healing wounds    |
| <input type="checkbox"/> nausea/vomiting                    | <input type="checkbox"/> increased bruising/nose bleeds                | <input type="checkbox"/> shortness of breath   |
| <input type="checkbox"/> weight loss/gain (unexplained)     | <input type="checkbox"/> heartburn/indigestion                         | <input type="checkbox"/> persistent cough      |
| <input type="checkbox"/> dizziness/lightheadedness/fainting | <input type="checkbox"/> tarry stool or blood in urine                 | <input type="checkbox"/> difficulty swallowing |
| <input type="checkbox"/> falls/accident/recent trauma       | <input type="checkbox"/> food intolerances (that reproduce your pain)  | <input type="checkbox"/> headaches             |
| <input type="checkbox"/> loss of balance while walking      | <input type="checkbox"/> blood in sputum                               | <input type="checkbox"/> muscle weakness       |
| <input type="checkbox"/> heavy pulsing in abdomen           | <input type="checkbox"/> prolonged or excessive menstruation           | <input type="checkbox"/> unrelenting pain      |

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> cancer.....Current or in remission         | <input type="checkbox"/> pneumonia                              | <input type="checkbox"/> thyroid problems   |
| <input type="checkbox"/> heart problems _____                       | <input type="checkbox"/> tuberculosis                           | <input type="checkbox"/> diabetes           |
| <input type="checkbox"/> chest pain/angina                          | <input type="checkbox"/> asthma/allergies                       | <input type="checkbox"/> hyper/hypoglycemia |
| <input type="checkbox"/> high blood pressure                        | <input type="checkbox"/> rheumatoid arthritis                   | <input type="checkbox"/> ketoacidosis       |
| <input type="checkbox"/> circulation problems _____                 | <input type="checkbox"/> other arthritic condition              | <input type="checkbox"/> epilepsy           |
| <input type="checkbox"/> blood clots                                | <input type="checkbox"/> incontinence bowel or bladder          | <input type="checkbox"/> osteoporosis       |
| <input type="checkbox"/> stroke                                     | <input type="checkbox"/> bladder/urinary tract infection        | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> anemia, hemophilia or other blood disorder | <input type="checkbox"/> other kidney problem/infection         | <input type="checkbox"/> depression         |
| <input type="checkbox"/> chest pain not relieved by rest            | <input type="checkbox"/> bone or joint infection                | <input type="checkbox"/> liver problems     |
| <input type="checkbox"/> history of cardiac stent                   | <input type="checkbox"/> pelvic inflammatory disease            | <input type="checkbox"/> hepatitis          |
| <input type="checkbox"/> congenital heart defect                    | <input type="checkbox"/> chemical dependency (i.e., alcoholism) | <input type="checkbox"/> fibromyalgia       |
| <input type="checkbox"/> sexually transmitted disease/HIV           | <input type="checkbox"/> pituitary/adrenal/hormone problems     | <input type="checkbox"/> ulcers             |

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

- |  |                                     |   |
|--|-------------------------------------|---|
| <input type="checkbox"/> cancer              | <input type="checkbox"/> diabetes   | <input type="checkbox"/> tuberculosis     |
| <input type="checkbox"/> heart problems      | <input type="checkbox"/> stroke     | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> depression | <input type="checkbox"/> blood clots      |

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

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 any medications you are taking (INCLUDING pills, injections, and/or skin patches):

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Name: \_\_\_\_\_

Please list any surgeries or other medical conditions for which you have been hospitalized:

\_\_\_\_\_  
\_\_\_\_\_

List special tests performed for your current problem (x-ray, MRI, labs, etc): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

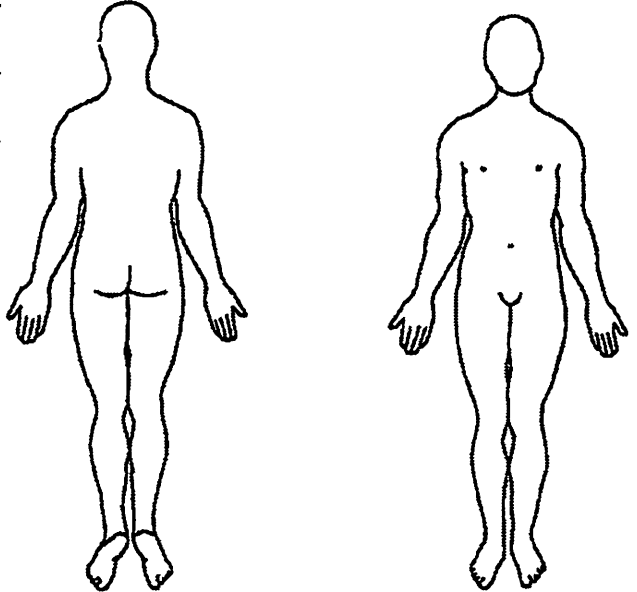
How may we help you today? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Body Chart:

Please mark on the figure to the right to represent your symptoms using the following symbols.

- X** Sharp pain
- O** Dull/aching pain
- zzz** Numbness
- =** Tingling
- ~** Radiating pain



**Aggravating Factors:** Identify up to 3 important positions or activities that make your symptoms worse:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Easing Factors:** What seems to make your symptoms better?

\_\_\_\_\_

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

Your current level of pain while completing this survey: \_\_\_\_\_

The best your pain has been during the past 24 hours: \_\_\_\_\_

The worst your pain has been during the past 24 hours: \_\_\_\_\_

Are you afraid that physical activity will cause an increase in your pain?  Yes  No

Are you afraid that moving the area in question will be harmful to you?  Yes  No

Treatment received previously for this problem: \_\_\_\_\_

What are your expectations from physical therapy? \_\_\_\_\_