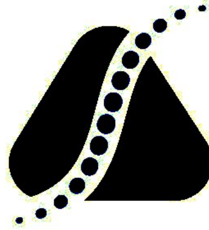

DELTA
PHYSICAL THERAPY

Wellness Movement Screen

Full Name: ____ Date ______/________/________

Date of Birth: ______/_______/________ Phone Number: _______________

Address: ____

Email Address: ____

What is your past medical history? Please list any major medical concerns, allergies or orthopedic surgeries:

____

____

____

Are you presently under the care of a physician? If so please note date last seen.:

____

____

____

What brings you to the clinic today? What movements are bothersome or could be improved upon? Give a brief description below:

____

____

____

____

Clinical Findings

____

____

____

____

____

____

____

____

Therapist Recommendations

____

____

____

____

____

I ________________________________ fully understand the nature and purpose of this *"Wellness Movement Screen."* I consent to evaluation by a licensed physical therapist practicing at ***Delta Physical Therapy***. I understand the procedure(s) for this screen including the potential for possible discomfort and/or injury. I understand this screen is no guarantee to improve my condition. I have been given an opportunity to ask questions related to the wellness screen as well as course of action from this point forward. I confirm that I have read and fully understand this consent form.

____ ________________

Patient/Legal Representative Signature Date/time

____

Therapist Signature