Physical Therapy Medical Screening

Name: _____

Date: _____ DOB: _____

Sex: M F Age: _____ Ht: _____ Wt: _____

Tobacco: Y N

Occupation: _____

Referring Physician: _____

_____

Past Surgical History (include year(s)): _____

_____

_____

Current Medications (please provide list or photocopy):

_____

_____

Recent diagnostic imaging (MRI, XR, CT): _____

_____

PAST MEDICAL HISTORY: (Circle each condition you currently OR have ever had in the past)

Cancer Diabetes I or II Stroke Blood Clot Pacemaker Depression Seizures Ulcers Asthma

High Blood Pressure Heart Disease Liver Disease Kidney Disease Lunge Disease Fibromyalgia

Osteoporosis Osteoarthritis Rheumatoid Arthritis Allergies: _____

Other(s): _____

Recently I have been experiencing (circle all that apply):

Fever/Chills/Sweats	Unexplained weight loss	Increased pain at night/rest		Difficulty swallowing
Difficulty speaking	Dizziness	Poor balance/Falls	Vision changes	Numbness or Tingling
Nausea/Vomiting	Chest pain	Shortness of breath	Changes in appetite	Pain with meals
Unusual pain with menstruation		Change in bowel or blader control		NONE

CURRENT SYMPTOMS: Where is your PRIMARY symptom located? _____

Approximately when did this symptom begin? _____ (Injury or Gradually)

Have you ever had this problem before? (Y / N) IF YES, please answer the next two questions:

What treatments helped? _____ What treatments failed? _____

I certify that the above information is correct.
(patient/guardian signature): _____ Date: _____

Reviewed by (physical therapist signature): _____ Date: _____