

**Medical Screening Form**

**NAME:**

**DOB:**

**Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Precautions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever been told you have any of these conditions? Please CHECK**

Anxiety Heart Disease

Cancer Angina/Chest Pain

Depression Stroke

Diabetes Osteoporosis

High Blood Pressure Rheumatoid Arthritis

**Do any of your immediate family members have these conditions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do YOU have history of: PLEASE CHECK**

Allergies HIV/AIDS

Headaches Seizures

Bronchitis Pacemaker Placement

Kidney Disease Cardiac Surgery

Skin Ulcers Hepatitis A/B/C

Circulation Problems Tuberculosis

**Please list all MEDICAL CONDITIONS or SURGERIES you have had that are not mentioned above.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**In the past 3 months have you experienced or do you experience: PLEASE CHECK**

A change in YOUR health Nausea/Vomiting Fever/Chills/Night Sweats

Unexplained weight loss Numbness/tingling Changes in Appetite

Shortness of breath Difficulty Swallowing Dizziness

Leg Cramps Urinary Tract Infections Changes in Bladder Function

Changes in Bowel Function Pregnant Feeling down

Under stress

**How are you able to sleep at night?**

Fine Moderate Difficulty Only with Medication

**Do you have a problem with:**

Hearing Vision Speech Communication Memory Swallowing

**Please list all medications you take and what they are for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List allergies (i.e. allergies to medications, latex, adhesives, iodine, shellfish, etc.)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you or have you in the past smoked tobacco? Yes No**

If yes, \_\_\_\_\_\_\_\_ packs/day x \_\_\_\_\_\_\_ years Date of last tobacco use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you drink alcoholic beverages? Yes No**

**Please fill in the information below:**

What is your occupation? ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you do for fun? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you live: Alone Assisted Living With Family Other

Do you live in a:

1 story home 2 story home Mobile Home Apartment Condo

How many stairs do you have to enter your home? \_\_\_\_\_\_\_\_ No stairs Ramp

Do you have railings? Right Left None

How many stairs do you have inside? \_\_\_\_\_\_\_\_\_\_\_ None

Do you have railings? Right Left None

**Current condition:**

How long have you had this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Onset Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your symptoms worse in: AM As day progresses PM

Are your symptoms now: Better Worse Same as when they started?

Do you have trouble with: Bending Sitting Rising Standing Walking Lying

What was your level of function before this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently exercise? Yes No If yes, how often? ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical examination \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When do you go back to see your doctor? \_\_\_\_\_\_\_\_\_\_

Who is your physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What are three (3) important activities you are unable to do, or are having difficulty with because of your injury or problem?**

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

**Pain/Symptom Scale: 0 = No pain, 10 = worst pain (Emergency Room pain)**

**What is the worst your pain or symptom gets? (circle one)**

**0 1 2 3 4 5 6 7 8 9 10**

**What is the best your pain or symptom gets? (circle one)**

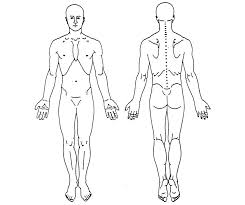
**0 1 2 3 4 5 6 7 8 9 10**

**What is your current level of pain/symptom? (circle one)**

**0 1 2 3 4 5 6 7 8 9 10**

**Please use the diagram below to indicate where you feel symptoms right now. Use the following key to indicate the different types of symptoms.**

**KEY: Pins and needles = 00000 Stabbing = ///// Burning = XXXXX Deep Ache = ZZZZZ Numbness = 88888**

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**Therapist Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License # \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_**