Medical Screening Form

Name:_____ Date:_____

Please circle YES or NO

Do You Have A History Of:	SELF	FAMILY
Diabetes?	Yes…No	Yes…No
High Blood Pressure?	Yes…No	Yes…No
Heart Attack?	Yes…No	Yes…No
Heart Disease?	Yes…No	Yes…No
High Blood Cholesterol?	Yes…No	Yes…No
Smoking?	Yes…No	Yes…No
Chest Pain?	Yes…No	Yes…No
Dizziness/Fainting?	Yes…No	
Shortness of Breath?	Yes…No	
Ankle Swelling?	Yes…No	
Night Coughing?	Yes…No	
Stroke?	Yes…No	Yes…No
Cancer?	Yes…No	Yes…No
Osteoporosis?	Yes…No	Yes…No
Osteoarthritis?	Yes…No	Yes…No
Rheumatoid Arthritis?	Yes…No	Yes…No
Rheumatic Disease?	Yes…No	Yes…No
Alcohol Use?	Yes…No	
↳ Current number drinks/week?	_____	
Allergies?	Yes…No	
↳Type?	_____	
Asthma?	Yes…No	
↳ Always have inhaler with you?	Yes…No	
Childhood Diseases?	Yes…No	
Falling?	Yes…No	
↳Number of times in last year?	_____	
Headaches?	Yes…No	
Kidney Disease?	Yes…No	
Lung Disease?	Yes…No	
STDs?	Yes…No	
Seizures?	Yes…No	
Pacemaker/Defibrillator?	Yes…No	
Assistive Device (e.g. cane)?	Yes…No	

In the Past 3 Months, Have You Experienced:	
Unexplained change in your health?	Yes…No
↳If yes, please describe:	
_____	
Explained illness or injury?	Yes…No
↳If yes, please describe:	
_____	
Unexplained weight change?	Yes…No
Night sweats?	Yes…No
Fever?	Yes…No
Numbness or tingling?	Yes…No
Changes or difficulty with bowel?	Yes…No
Changes or difficulty with bladder?	Yes…No

In the past month, have you frequently been bothered by feeling down, depressed or hopeless? ..... Yes … No

In the past month, have you frequently been bothered by having little interest in things or have you lost pleasure in doing things? ..... Yes … No

Do you have a problem with… (check all that apply)

☐ Hearing ☐ Speech
☐ Vision ☐ Communication

Do you regularly exercise? ..... Yes … No
Number of days per week?_____
Number of minutes per session?_____

What is your body weight?_____ Height? _____

Please list any medicine allergies you may have:

_____
_____

Are you allergic to Latex? Yes…No Adhesives? Yes…No

Please list or provide a copy of the medications you are currently taking: (Dosages not necessary)

_____
_____
_____

Please list any major surgeries in your past:

_____
_____
_____
_____

Other:

_____
_____
_____
_____
_____

Women:

Are you or could you be pregnant? ..... Yes … No

Patient/Representative Signature:_____ Therapist Signature: _____

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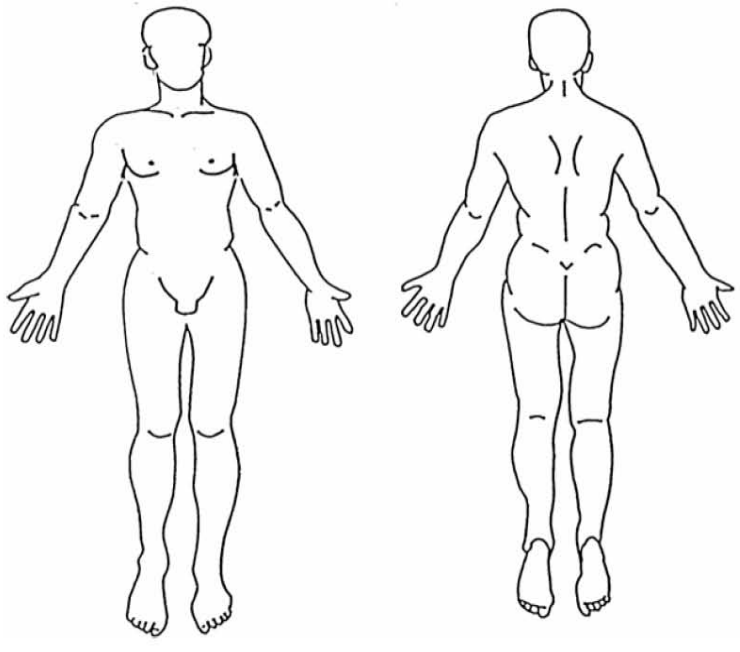
Name:_____ Date:_____

Please use the diagram below to indicate where you feel symptoms right now.

Use the key below to indicate the different types of symptoms:

KEY: Pins & Needles = oooooooo Stabbing = //////////
Burning = XXXXXX Deep Ache = ZZZZZZZ



Please mark your ***best (B), current (C), and worst (W)*** level of pain or symptom on the following line:

_____

0 1 2 3 4 5 6 7 8 9 10

(**0** = none → **10** = worst imaginable. Indicate level for each with B, C, and W)

What makes your pain or symptom worse?

_____

What makes your pain or symptom better?

_____

Are your symptoms: (check one)
□ Getting worse □ The same □ Improving

How are you able to sleep at night? (check one)
□ Fine □ Moderate Difficulty □ Only with Medication

Do you have pain at night? Yes … No

When (date) did your problem begin? _____

Have you been treated for this before? Yes … No
When? How? _____

PATIENT SPECIFIC FUNCTIONAL SCALE

Please list three (3) activities that you are having difficulty performing. Please rate your ability next to each activity

(**0** = unable to perform → **10** = can perform normally)

1. _____ _____
   0 1 2 3 4 5 6 7 8 9 10
2. _____ _____
   0 1 2 3 4 5 6 7 8 9 10
3. _____ _____
   0 1 2 3 4 5 6 7 8 9 10

Other Relevant Information? _____

_____

_____

_____

Patient or Representative Signature:_____ Date: _____

Reviewer Signature/Initials:_____ Date: _____