agilityhealth® plainwell | PHYSICAL THERAPY

Physical Therapy Medical Screening Questionnaire

Date:_____

Name:_____
Gender: M F Age: _____
Smoker: Y N Pregnant: Y N

Describe your regular exercise routine:

Medications	Dose	How Taken
1.		
2.		
3.		
4.		
6.		
7.		
8.		
9.		
10.		

Current Height: _____ Current Weight:_____
Any falls in the last 12 Months? Y N
Past Surgical History: (Please List and Date):_____
_____
_____

Past Medical History: Please circle each condition that you have been told you have (or had)

Cancer	Diabetes	Kidney Disease	Liver Disease	Stroke
High Blood Pressure	Heart Disease	Angina/Chest Pain	Ulcers	Fibromyalgia
Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Sexually Transmitted Disease	
Allergies/Asthma	Lung Disease	Have you had a recent illness (explain if yes)_____		
Do you take blood thinners? Y N		Are you allergic to latex? Y N Other:		

Currently I am experiencing (circle all that apply):

Unexplained weight loss	Numbness or tingling	Fever/chills/sweats	Poor balance (falls)
Depression	Shortness of Breath	Changes in appetite	Difficulty swallowing
Changes in bowel or bladder function		Dizziness	Headaches
		Nausea/Vomiting	Increased pain at night

CURRENT SYMPTOMS:
Where are you currently having symptoms?_____
What date (approximately) did your present pain start? _____
How (gradually, suddenly, injury)? _____
Have you had any treatment for this problem? _____
If so, how was the problem treated? _____
Have you had an x-ray, MRI, or other imaging study? (Describe)_____
What is your personal goal for therapy? _____

TURN OVER

On the scales below, please circle the number which best represents the severity of your pain is.

Average for the last 48 hours:

No pain	0	1	2	3	4	5	6	7	8	9	10	**Worst Pain Imaginable**

Best for the last 48 hours:

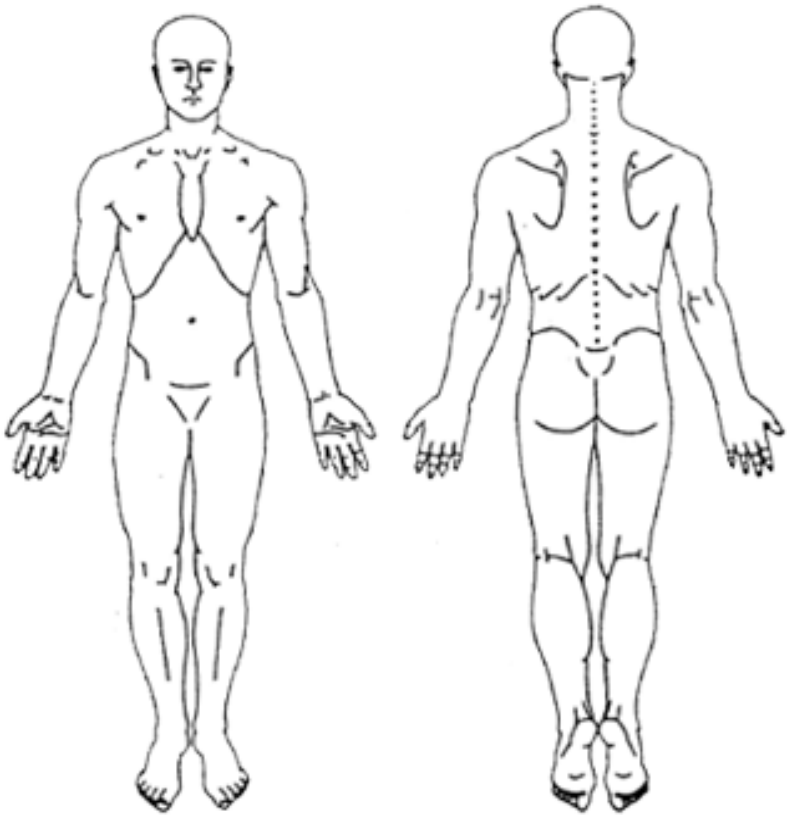
No pain	0	1	2	3	4	5	6	7	8	9	10	**Worst Pain Imaginable**

Worst for the last 48 hours:

No pain	0	1	2	3	4	5	6	7	8	9	10	**Worst Pain Imaginable**

Body Chart:

Indicate where your pain is located and what type of pain you feel at the present time. Fill in the areas on the body diagram with the appropriate symbols below to describe your pain. Do not indicate areas of pain that are not related to your present injury or condition.



KEY:

/// STABING
XXX BURNING
OOO PINS AND NEEDLES
=== NUMBNESS

For the therapist

+/- cough/sneeze
+/-saddle anesth
+/- bwl/bladder chang
+/- numb/ting

What makes your symptoms better?

_____

_____

Please circle the activities which make your pain worse:

lying down	standing	walking	stress	sitting
bending	lifting	first thing in the AM	end of day	

Any other activities that make your pain worse?_____

_____

Please list the best and worst time of day for your symptoms:

Best - _____

Worst - _____

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

1)
2)
3)

Below for the Therapist

Rating ____
Rating ____
Rating ____
AVG ____