Premier Physical Therapy Medical Screening Questionnaire

Date:	Gender: M F	Occupation:
Name:	Smoker: N Y	
Age:	Pregnant: N Y	

Past medical history: Please circle each condition that you have

Cancer	Diabetes	Kidney Disease	Fibromyalgia
High Blood Pressure	Heart Disease	Angina/ Chest Pain	Ulcers
Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Stroke
Allergies/Asthma	Lung Disease	Liver Disease	Seizures

Other: ____________________

Do you take blood thinners? YES NO Are you allergic to Latex? YES NO

Orthopedic injuries: ____________________

Have you had two or more falls in the last year? YES NO

Have you had any falls with injury in the past year? YES NO

Past surgical history: Please list with date

____

____

____

Please list all current medications including dosage and route of administration:

____

____

Currently I am experiencing (circle all that apply):

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

Describe your regular exercise activities: ____________________

Do you have any barriers to learning? If so please list. ____________________

What are your goals for physical therapy? ____________________

BODY CHART:

Please shade the areas where you feel pain on the chart to the right. Mark the chart with X's where you feel tingling or numbness. Lastly, rate your pain in **the last 48 hours** using the scale below.

Average pain = ________

Worst pain = ________

Lowest pain= ________

No pain = 0

0 1 2 3 4 5 6 7 8 9 10

Worst pain imaginable =10