Medical Screening Questionnaire

Name: _____ **Date:** _____

Gender: **M F** Age: _____ Height: _____Weight: _____ Pregnant: **Yes/No**

Past Surgical History (list all &date):_____

Occupation: _____ Describe your regular exercise routine:_____

Currently I am experiencing (circle all that apply): Fever/chills/sweats Poor balance (falls) Dizziness

Unexplained weight loss Numbness or Tingling Changes in appetite Difficulty swallowing Depression

Shortness of breath Headaches Changes in bowel or bladder function Nausea /Vomiting Increased pain at night

How are you able to sleep at night? **Fine** **Moderate Difficulty** **Only with medication**

Where are you currently having symptoms? _____

What symptoms are you currently experiencing? _____

What date (approximately) did your present pain start? _____

How did your problem start? (Gradually, suddenly, injury)? _____

My symptoms are currently: **Getting better** **About the same** **Getting worse**

Have you had this problem before: **YES / NO** What treatment have you received for this problem? _____

Have you had an x-ray, MRI, or other imaging study for this problem? **YES / NO**

Do you have any barriers to learning, if so list? _____

List Current Medications

Name of Medication	Dosage	Route- (topical, inject, oral)	How Often
1.			
2.			
3.			
4.			
5.			

□ Aspirin/Ibuprofen □ Cold Medicine □ Laxative □ Other _____
□ Antacids □ Cough Medicine □ Diet Pills
□ Sleeping aids □ Allergy Relief □ Vitamins/supplements □ Other _____

Past Medical History:	**Y**	**N**		**Y**	**N**
Arthritis	□	□	High Blood Pressure	□	□
Asthma/ Chronic Bronchitis	□	□	HIV/AIDS	□	□
Bowel/Bladder Problems	□	□	Osteoporosis	□	□
Cancer	□	□	Rheumatoid Arthritis	□	□
Chest Pain	□	□	Stroke	□	□
Diabetes	□	□	Alcoholism	□	□
Emphysema	□	□	Drug Abuse	□	□
Epilepsy/Seizures	□	□	Are you currently pregnant?	□	□
Heart Disease/Attack	□	□	Do you have a pacemaker?	□	□
Hepatitis	□	□	Do you have any surgical implants?	□	□

Do you smoke? **YES** / **NO** If so, how much per day? _____

Have you had a recent illness (explain if yes)? _____

Do you take blood thinners? **YES** / **NO** Are you allergic to latex? **YES** / **NO**

During the past month, have you often been bothered by feeling down, depressed, or hopeless? **YES** / **NO**

During the past month, have you often been bothered by little interest or pleasure in doing things? **YES** / **NO**

Have you fallen two times or more in the past year? **YES** / **NO**

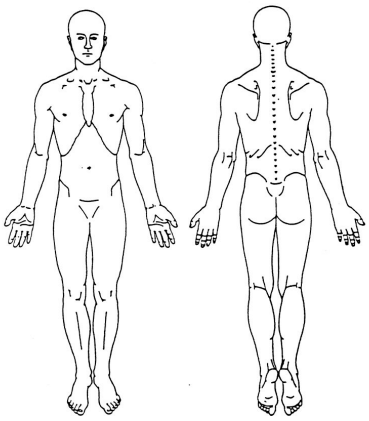
Have you sustained an injury as a result of a fall in the past year? **YES** / **NO**

Do you feel unsteady when walking or standing? **YES** / **NO** Are you fearful of falling? **YES** / **NO**

Overall, how would you rate your health in general? **Poor Fair Good Excellent**

What is your personal goal for therapy? _____

Body Chart: Please mark the areas where you feel pain on the chart below.



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**

What makes your symptoms better? _____

_____

What makes your symptoms worse? _____

_____

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

Worst - _____

Best - _____

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)_____