MEDICAL SCREENING QUESTIONNAIRE FOR PHYSICAL THERAPY SERVICES

Date:_____ Time:_____:_____AM/PM Date of Birth: _____/_____/_____ AGE: _____
Legal Name:_____ Nickname: _____ Gender: □ M □ F
HEIGHT: _____ft _____in WEIGHT: _____# Dominant Hand: □ R □ L
How did you hear about us? □Physician:_____ □Website □ Word of Mouth:_____ □Other:_____

PAST/CURRENT MEDICAL HISTORY INCLUDES: Please Circle All That Apply

Cancer	Blood disorder	Osteoarthritis	Endometriosis
Diabetes I or II	Blood clots/DVT	Rheumatoid Arthritis	STD
Kidney problems	Bone/joint infection	Fibromyalgia	Pelvic inflam. disorder
Bladder issues/UTI	Addiction	Migraines/Headache	Pregnancy
Liver problems	Depression	Lung problems	Vision/Eye problems
Stroke	Steroid Use	Allergies	Hepatitis
High Blood Pressure	Asthma	Seizures/Epilepsy	Illness/Infection
Heart problems	Tuberculosis	Ulcers	Multiple Sclerosis
Angina/Chest Pain	Thyroid problems	Pneumonia	Metal/Implants
Pacemaker	Osteoporosis/penia	Smoker	Muscular Dystrophy
Low Blood Sugar/hypo-glycemia	Circulation/vascular problems	Broken bones/fractures Memory Loss/Head Injury	Parkinson Disease Other:

ARE YOU CURRENTLY OR HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING:
Please Circle All That Apply

Fatigue	Difficulty sleeping	Numbness/tingling	Joint pain/swelling
Weight loss/gain	Loss of Sensation	Difficult eating/swallowing	Difficulty with mobility
Pain at night or rest	Headaches	Chest pain	Vision considerations
Fevers/Chills/Sweats	Poor balance	Palpitations	Hearing problems
Nausea/Vomiting	Falls	Menstrual changes	Depression
Muscle weakness	Dizziness/lightheaded	Bowel/Bladder issues	Appetite Change
Shortness of Breath	Fainting	Heartburn/indigestion	Cough

Are there any customs/religious beliefs that may affect care? □Y □N
Are you sensitive to (circle): □Heat □Cold □Light □Noise other:_____
Are you allergic to any medications? □Y □N Anti-inflammatories? □Y □ N
Please explain anything checked/noted above: _____
_____
Please list all current medications, supplements, and previous medications taken on consistent basis: _____
_____
Past surgical history (list all & dates): _____
List any daily activities you are experiencing difficulties with: _____
Have you had Physical Therapy or other therapies before? □Y □N For your current complaint? □Y □N
What are your goals for physical therapy: _____
_____
Additional Comments: _____
_____

Patient Signature:_____Date:_____

For Excel PT:
VITALS: Temp: _____°F
HR: _____bpm
BP: _____/_____
RR: _____ Initials: _____