

Medical Screening Form

Patient:

Name: _____ Birthdate: _____ Today's Date _____
Age: _____ Occupation: _____
Height, Weight: _____ Employer: _____
Did a physician refer you? If yes whom? _____ Next scheduled appointment _____
If no, do you have a doctor you would like us to communicate with regarding your care? _____
Physician's contact information: _____

Medical/Surgical/Family History:

a - Please put a circle if you or a box if your family has ever had:

- | | | |
|--------------------------|-----------------------|------------------------------------|
| 1 - Arthritis | 10 - Osteoporosis | 19 - Blood Disorders |
| 2 - Heart problems | 11 - Lung problems | 20 - High blood pressure |
| 3 - Stroke | 12 - Head injury | 21 - Allergies |
| 4 - Multiple sclerosis | 13 - Cancer | 22 - Parkinson disease |
| 5 - Seizures/epilepsy | 14 - Thyroid problems | 23 - Skin disease |
| 6 - Infectious disease | 15 - Kidney problems | 24 - Repeated infections |
| 7 - Depression | 16 - Broken bones | 25 - Muscular dystrophy |
| 8 - Circulation problems | 17 - Diabetes | 26 - Low blood sugar |
| 9 - Ulcer | 18 - Hepatitis | 19 - Developmental/growth problems |

b - Have you **ever** had surgery? Yes/No

If yes, please describe, and include dates: _____

c - Please circle if you have had any of the following symptoms/conditions in the last year.

- | | | |
|------------------------------|--------------------------------|-------------------------|
| 1 - Chest pain | 9 - Difficulty walking | 16 - Fever/chills/sweat |
| 2 - Heart palpitations | 10 - Joint pain or swelling | 17 - Headaches |
| 3 - Cough | 11 - Night pain | 18 - Hearing problems |
| 4 - Shortness of breath | 12 - Difficulty sleeping | 19 - Vision problems |
| 5 - Dizziness | 13 - Loss of appetite | 20-- Pregnant |
| 6 - Coordination problems | 14 - Nausea/Vomiting | 21—Depression |
| 7 - Weakness in arms or legs | 15 - Bowel or bladder problems | 22—Highly stressed |
| 8 - Loss of balance | | 23 - Other _____ |

Social History:

a - With whom do you live? _____

b - Sleep Patterns: Hours: _____ # times awake/night _____

Reason for wakefulness _____

c - Do you use an assistive device for mobility? _____, If so, what? _____

d - Do you smoke? _____ Do you drink alcohol? _____

e - How many days a week do you exercise? _____

f - How would you rate your health? Excellent Good Fair Poor

g - When was the date of your last complete physical? (Month/year/physician) _____

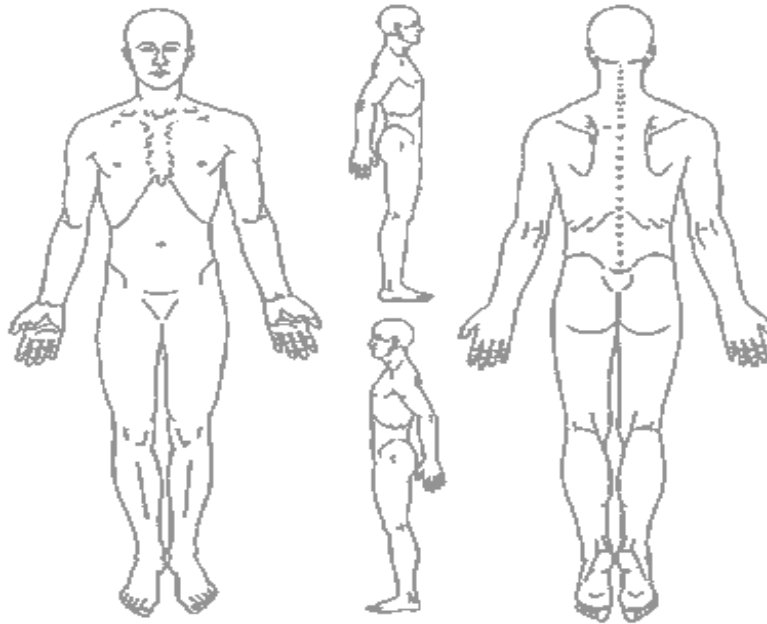
Please rate your pain on a scale from 0-10, 0 being none and 10 being maximum pain you could experience.

Today: _____ Best: _____ Worst: _____ Worse am / pm with movement / being stationary

Activities that cause you pain: _____

Mark areas on the drawing below where you feel the described sensations using the appropriate symbols. Include all affected areas.

Dull Ache (*) Stabbing (/) Numbness (X) Pin/Needles (+) Burning (O)



Current condition(s)/chief complaint(s):

a - When was the onset of your problem/injury? _____

b - Was this condition related to an auto or work accident? _____

c - Describe the problem(s) for which you seek therapy? _____

d - How did the problem(s) begin? _____

e - Have you had this problem before? _____

f - What are your goals for therapy? _____

g - Have you or are you seeing anyone else for the problem(s) _____

Medication:

Do you take any prescription or non-prescription medications? Yes/No

If yes, please list _____

Patient's Signature _____ Date: _____