A. Fox Physical Therapy, P.C.
Innovative Therapies...Caring Treatment

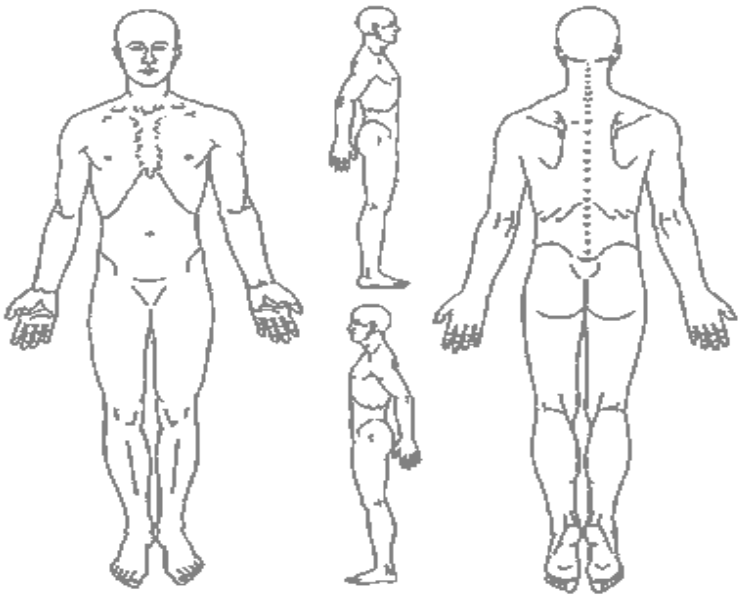
Medical Screening

Name:_____ DOB:_____ Date: _____

Please rate your pain on a scale from 0-10 over the last 24 h, 0 being none and 10 being maximum pain you could experience. Current:_____ Best:_____ Worst:_____

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

Chest pain	Night pain	Fever/chills/sweat
Cough	Difficulty sleeping	Loss of balance
Shortness of breath	Loss of appetite	Bowel or bladder problems
Dizziness	Nausea/Vomiting	Other _____



Please mark the areas on the drawing below where you feel your discomfort or symptoms.

Medications:
Do you take any prescription or non-prescription medications? Yes/No? Please list or provide list:

Medication _____ Dosage _____ Frequency _____ Route_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient's Signature_____Date: _____