MEDICAL SCREENING FORM

Name:_____ Age:_____ Occupation:_____

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

In the past 3 months have you had or do you experience:

Changes in your health……Yes…No
Changes in Appetite……Yes…No
Changes in bowel/bladder function……Yes…No
Dizziness……Yes…No
Difficulty Swallowing……Yes…No
Fever/Chills/Sweats……Yes…No
Infections ……Yes…No
Nausea/Vomiting……Yes…No
Numbness/Tingling……Yes…No
Shortness of Breath……Yes…No
Unexplained Weight Change……Yes…No

What prescription medications are you taking?

_____

__ _____

What over the counter medications are you taking?

_____

_____

Tobacco Use: Yes…No

If Yes: Packs per day:____ How many years:____

Alcohol consumption: Yes…No

If Yes: How many drinks per week: _____

Caffeine consumption: Yes…No

If Yes: Number of drinks per day:_____

Do you have a problem with:

☐ Hearing ☐ Vision ☐ Speech ☐ Communication

Present/Past Medical Conditions (circle):

AIDS……Yes…No
Allergies/Asthma……Yes…No
Angina/Chest Pain……Yes…No
Anxiety or Panic Disorders……Yes…No
Asthma……Yes…No
Back Pain
(neck pain, low back pain,
degenerative disk, stenosis) ……Yes…No
Cancer……Yes…No
Depression……Yes…No
Diabetes Type I or II……Yes…No
Diabetes……Yes…No
Fatigue……Yes…No
Gastrointestinal Disorder
(ulcer, hernia, reflux, bowel,
liver, gall bladder) ……Yes…No
Headaches……Yes…No
Heart Attack…… Yes…No
Heart Disease/CHF……Yes…No
Hepatitis……Yes…No
High Blood Pressure……Yes…No
Incontinence……Yes…No
Kidney Disease……Yes…No
Multiple Sclerosis……Yes…No
Osteoarthritis……Yes…No
Osteoporosis……Yes…No
Parkinson's…… Yes…No
Peripheral Vascular Disorder ……Yes…No
Pregnancy……Yes…No
Prosthesis/Implants ……Yes…No
Respiratory Disorders
(ARDS, COPD, Emphysema)……Yes…No
Rheumatoid Arthritis……Yes…No
Scoliosis……Yes…No
Seizures……Yes…No
Sleep Dysfunction……Yes…No
Stroke (or TIA)…… Yes…No
Thyroid Problems……Yes…No

Other:_____

Has anyone in your immediate family been diagnosed/treated for any of the conditions listed above? Yes…No

If yes please specify:_____

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Chief complaint:_____

Secondary or related complaint:_____

Date of onset:_____ Was the onset ☐ Gradual ☐ Sudden

Since onset, has it gotten ☐ Worse ☐ Better ☐ Same

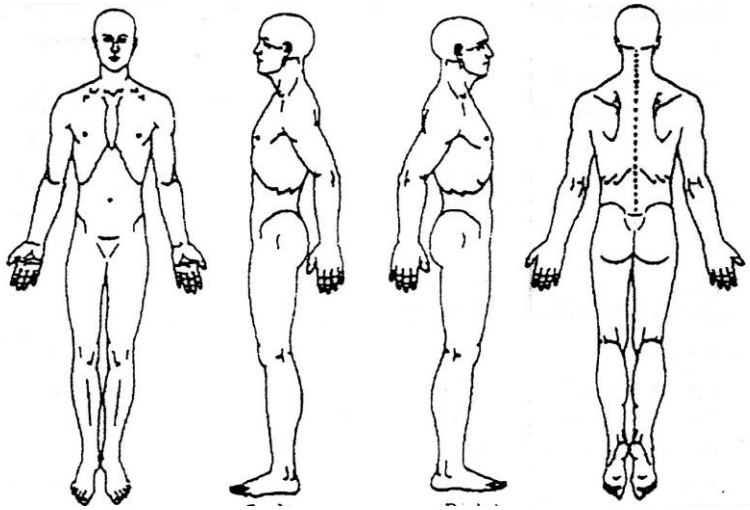
Describe what caused the pain:_____

What aggravates your pain? _____

What relieves your pain? _____

PAIN CHART
Please Mark Areas of Pain using these Codes!

+++	Burning
###	Dull/Ache
***	Numbness/Tingling
═══	Throbbing
000	Stabbing/Sharp



(FRONT) (LEFT) (RIGHT) (BACK)

SEVERITY OF PAIN

On a scale of 0 (being no pain)-10 (being the worst imaginable pain) please rate the following:

Chief Complaint:_____

At its BEST (0-10)_____ At its WORST (0-10)_____ AVERAGE (1-10)_____

Secondary Complaint (if any):_____

At its BEST (0-10)_____ At its WORST (0-10)_____ AVERAGE (1-10)_____

Current recreational/fitness activities:

_____

_____

_____

Goals for physical therapy:

_____

_____

_____

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