SIX POINTS PHYSICAL THERAPY

PROMOTING HEALING AND WELLNESS

Medical Screening Questionnaire

Name:_____**Date:** _____ **Age:**_____

Are you latex sensitive? ❑**Yes** ❑**No**

Do you smoke? ❑**Yes** ❑**No**

Do you ban a pacemaker? ❑**Yes** ❑**No**

FOR WOMEN: Are you currently prepant or tbink you might be pregnant? ❑**Yes** ❑**No**

ALLERGIES: List any ~~medication~~(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ falls
- ❑ numbness or tingling
- ❑ muscle weuaeu
- ❑ dizziness/lightheadedness
- ❑ beartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches

Have you EVER been diagnosed wtth any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia

Has anyone in your family(parents, brother, sisters) EVER been diagnosed with any of the following conditions (check an that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ high blood pressure
- ❑ diabetes
- ❑ stroke
- ❑ depression
- ❑ tuberculosis
- ❑ thyroid problems
- ❑ blood clots

During the past month have you been feeling down. depressed or hopeless? ❑**YES** ❑**NO**

During the past mon\h have you been bothered by havinl little inlenat or pleasure in doing tbings? ❑**YES** ❑**NO**

❑ **If yes to either, is this something with which you would like help?** ❑**YES** ❑**YES, but NOT today** ❑**NO**

Please list any medications YOU an currently taking (INCLUDING pills, lnjections, and/or skin patches):

Have you ever taken steroid medications for any medical conditions? ❑**YES** ❑**NO**

Have you eve!' taken blood thinning or anticoagulant medications for any medical conditions? ❑**YES** ❑**NO**

❑ **Please list any surgeries or other conditiona for which you have been hospitalized. including dates:**

_____

What date (roughly) did your present problem start?_____

My symptoms are currently: ❑ Getting Better ❑ Getting Worse ❑ Staying about the same

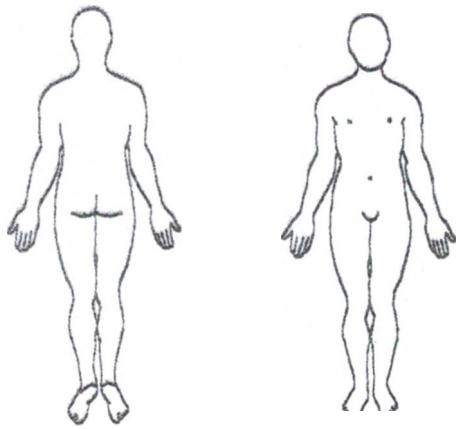
Treatment received so far for this problem (chiropractic, injections, surgery, etc): _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc.)

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ Shooting/sharp pain
O Dull/aching pain
||| Numbness
= Tingling



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

Using the 0 to 10 the scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Circle your current level of pain while completing this survey: ...0...1...2...3...4...5...6...7...8...9...10...

Circle the best your pain has been during the past 24 hours: ...0...1...2...3...4...5...6...7...8...9...10...

Circle the worst your pain has been during the past 24 hours: ...0...1...2...3...4...5...6...7...8...9...10...

Easing Factors: Identify up to 3 important positions or activities that make your symptoms *better:*

1._____
2._____
3._____

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.

1._____
2._____
3._____

Therapist Use:
Rating: _____
Rating: _____
Rating: _____

Average:_____

Therapist Use:

Unable to Perform 0 1 2 3 4 5 6 7 8 9 10 Able to perform at same level as before injury (problem)

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After activity
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After activity

Patient Signature:_____