Advanced Physical Therapy and Fitness
Patient History/Medical Screening

Name:_____ Age:_____ Date of birth:_____

Please briefly describe why you are coming to physical therapy:_____

_____

Is this problem related to an injury at work? YES NO Is it related to an automobile accident? YES NO

Have you been treated for this condition before? YES NO If yes, please describe: _____

_____

Circle YES or NO

Have you or any member of your immediate family ever been told you have……

	SELF		FAMILY	
Cancer?.....	Yes	No	Yes	No
Which type?_____				
Diabetes?.....	Yes	No	Yes	No
Diet, oral medication or insulin control?				
High blood pressure?	Yes	No	Yes	No
Heart disease?	Yes	No	Yes	No
If yes, describe:_____				
Angina/chest pain?.....	Yes	No	Yes	No
Stroke?.....	Yes	No	Yes	No
Osteoporosis?.....	Yes	No	Yes	No
Osteoarthritis?.....	Yes	No	Yes	No
Rheumatoid arthritis?..	Yes	No	Yes	No
Mental illness?.....	Yes	No	Yes	No

Do you currently have, or have you had:

Allergies?.....	Yes	No
Asthma?.....	Yes	No
Bronchitis?.....	Yes	No
Kidney disease?.....	Yes	No
Rheumatic fever?.....	Yes	No
Ulcers?.....	Yes	No
Sexually transmitted disease?	Yes	No
Seizures?.....	Yes	No
Circulatory problems?.....	Yes	No
Dizziness/fainting spells?.....	Yes	No
Pacemaker?.....	Yes	No
Implanted heart defibrillator?	Yes	No
Hearing aids?.....	Yes	No
Problems with your eyesight?	Yes	No
Metal implants?.....	Yes	No
Radioactive implants?.....	Yes	No
Broken bones?.....	Yes	No
Where:_____		
Surgery?.....	Yes	No
Describe:_____		
_____		

Circle YES or NO

In the past 3 months have you had or are you currently experiencing:

A change in your health?.....	Yes	No
Nausea/vomiting?.....	Yes	No
Fever/chills/sweats?.....	Yes	No
Unexplained weight change?.....	Yes	No
Numbness or tingling?.....	Yes	No
Difficulty swallowing?.....	Yes	No
Changes in appetite?.....	Yes	No
Changes in bowel or Bladder function?.....	Yes	No
Change in breathing/shortness Of breath?.....	Yes	No
Dizziness?.....	Yes	No
Any infection?.....	Yes	No
If yes, describe:_____		

Are you currently:

Pregnant?.....	Yes	No
Depressed?.....	Yes	No
Under stress?.....	Yes	No

Do you or in the past have you smoked tobacco? Yes No

If yes, _____ packs x _____ years.

Last tobacco use: _____

Do you drink alcoholic beverages? Yes No

If yes, _____/week.

Date of last physical examination:_____

How do you learn best? (check one)

___seeing ___hearing ___doing

Approximate: height_____and weight_____

Please list all the medications and supplements **with dosages** you are currently taking.

_____
_____
_____
_____

Are your symptoms: (check one)
___getting worse ___the same ___getting better

How are you able to sleep at night? (check one)
___fine
___moderate difficulty
___only with medication
___wake ___times per night regardless

I currently have difficulty: (check all that apply)

___driving	___getting up from a chair
___walking	___bending at the waist
___standing	___lifting
___reaching	___dressing
___caring for personal hygiene	

If you are accustomed to regular exercise, are you still able to complete your exercise?
Yes No
If not, why?_____

This list provides some examples of words that may help describe your pain. Check all that apply.

___sharp	___throbbing	___heavy
___shooting	___ache	___tight
___burning	___tingling	___pulling
___dull	___numb	___stabbing

This list provides words that may help describe the behavior of your symptoms. Check all that apply.
___constant (***never*** goes away)
___intermittent (relieved with some positions or rest)
___occasional (daily or less frequent)
___infrequent (once a week or month)
___variable (sometimes worse than at other times)

Signature:_____

Date:_____

Please mark the location of your current symptoms on the body diagrams below.

Front **Back**